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Santa Barbara

Help-Seeking in English-Speaking Orthodox Jewish-Israelis: A Qualitative Study

A dissertation submitted in partial satisfaction of the requirements for the degree of

Doctor of Philosophy

in

Counseling, Clinical, and School Psychology

by

Ilyssa Silverman

Committee in charge:

Professor Steven R. Smith, Chair

Professor Merith Cosden

Professor Tania Israel

June 2014

The dissertation of Ilyssa Silverman is approved.

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Tania Israel

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Merith Cosden

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Steven R. Smith, Chairperson

June 2013

Help-Seeking in English-Speaking Orthodox Jewish-Israelis: A Qualitative Study

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by

Ilyssa Silverman

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how to juggle school, work and family. Your wisdom brought clarity to what often felt like chaos.

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- ≅ Provide clinical supervision
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- ≅ Maintain detailed case notes, develop treatment plans, and conduct case presentations.
- ≅ Attend individual and group supervision by licensed clinicians.

- ≅ Conduct client intakes, write integrated intake reports, and present cases to case assignment team.
- ≅ Administer and interpret integrated assessments and follow-up assessments to monitor progress.
- ≅ Manage case files, psychiatric notes, and submit insurance claims.
- ≅ Attend psychiatric consultation sessions with clients.

Psychology Assessment Center (PAC), UCSB (2008-2009, 2012)

Position: Student Clinician (2008-2009)

Supervisor: Steve Smith, Ph.D.

- ≅ Conduct intake interviews with children and adults seeking integrated assessment.
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- ≅ Receive supervision by a licensed neuropsychologist and interpret assessment results.
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- ≅ Prepare case files
- ≅ Assign cases to appropriate clinicians

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- ≅ Community relations/ publicity
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ABSTRACT

Help-Seeking in English-Speaking Orthodox Jewish-Israelis: A Qualitative Study

By

Ilyssa Silverman-Bass

This study explores the help-seeking process of English-speaking Orthodox Jews living in Jerusalem, Israel. There is a belief, backed by some research coming out of public mental health facilities in Jerusalem, that the religious community underutilizes traditional mental health resources (Rosen, Greenberg, Schmeidler & Shefler, 2008). The conclusion of the research proposes that the underutilization is likely due to stigma within the community. This study addresses the question: What is the process that Orthodox Jewish English-speaking immigrants in the Jerusalem community use to seek help in times of emotional stress? The study addresses both barriers and facilitators to resources for this community.

A qualitative, constructivist grounded theory approach was used in the collection and analysis of 26 interviews. Standards of trustworthiness as outlined by Morrow (2005) were used to ensure the rigor of the study. The result is an attachment theory-informed, nine-stage cyclical model of help-seeking as well as in-depth descriptive information about individuals' unique and culturally specific experience of the nine stages. Factors such as individuals' help-seeking filters, structural barriers (mainly transportation and cost) as well as community emphasis on privacy and therapist value-match are some of the barriers identified by participants as important in their help-seeking processes; these findings indicate a more complex explanation and understanding of why this population may not use government-funded resources. These findings also have important implications for theory, research,

practice and education.

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Chapter 1: Rationale and Research Questions

According to Arredondo and D'Andrea (1999), "Jews have been largely attributed an invisible status in the fields of counseling and psychology in general and within the multicultural counseling movement in particular" (p. 14). An in-depth review by Langman (1999) found that "multiculturalism has typically not included Jews" and "books, journals, classes, and conferences [in counseling and psychology] make little mention of Jews, Jewish issues, or anti-Semitism" (p. 2). In a review published by the ACA, Weinrach (2002) asserts that the counseling diversity literature fails to recognize "the notion of Jews as a culturally distinct group" (p. 300). Weinrach calls for the counseling psychology field to develop a literature on the topic of Jewish needs. Schnall (2006) notes a particular lack of literature about Orthodox Jews. *Orthodox,* in the context of this study, refers to Jews who adhere strictly to Jewish Law as dictated in the *Torah* (the old testament and the centuries of Jewish commentary that followed; Schnall, 2006). He notes that the little literature that exists about this population and stigma is from the early 1980's and there is reason to believe that seeking mental health resources has become more accepted in this population over time. He calls for research to better understand the needs of Orthodox Jews in particular, noting that because of a great priority on privacy and lack of availability of in-group therapists, many members of this group may prefer non-Orthodox therapists; this requires a body of literature available for non-Orthodox therapists to understand this unique population.

The following is a qualitative, constructivist grounded-theory-based exploration of help-seeking within the context of a specific population of Orthodox Jews: English-speaking, Orthodox and Ultra-Orthodox Jewish immigrants living in Jerusalem, Israel. It is also a personal journey into questions I, the primary researcher, have about the community I live

and work in: How do people get help? Are people getting help? Are people suffering in silence? There is a belief, backed by some research coming out of public mental health facilities in Jerusalem, that the religious community underutilizes traditional mental health resources (Rosen, Greenberg, Schmeidler & Shefler, 2008). The authors of this research conclude that this is likely due to stigma in the Orthodox world citing a finding that those with more religious upbringing reported higher levels of stigma. Stigma is cited as the explanation for the low percentages of religious clients at these clinics compared to the percentage of Orthodox individuals in the Israeli population.

There are many possible reasons, however, for the underutilization of these resources beyond the simple "stigma" rationale. These explanations include, but are not limited to: access to information about facilities, cost, transportation, lack of culturally competent care at the facilities, community beliefs (including stigma) about these resources and resources within the Orthodox community that may make public facilities less attractive or redundant. An exploration of the help-seeking and access to care literature for a variety of minority groups elucidates many of the domains salient to the population being studied. For English-speakers in Jerusalem, the above-mentioned barriers exist in addition to minority status, immigrant status, and language barriers. Looking at all of these factors in the existing literature is helpful in understanding the help-seeking process and access to care issues for this group.

Models of help-seeking behavior as well as research on access to care have explored the process by which individuals seek and succeed in accessing mental health services (Chartier-Otis, Perreault & Bélanger, 2010; Levkoff, Levy & Flynn Weitzman,1999; Ojeda & Bergstresser, 2008; Prins, Verhaak, Bensing, & van der Meer, 2008). The help-seeking

literature proposes theory underlying this process (Mechanic, 1962; Andersen, 1995) while the access to care literature tends to focus on the details, specific factors, standing between an individual with perceived need for treatment and available resources (Chartier-Otis et al., 2010). Among these factors, gender, minority status, religion, mental-health diagnoses, adult attachment, immigrant status and structural barriers to care (health insurance, transportation, etc.) are factors affecting the population being studied and have been cited as important in impacting both individual perceived need for treatment and access to appropriate services (Becker, Arrindell, Perloe, Fay & Striegel-Moore, 2010).

There is substantial research exploring help-seeking behaviors and access to care for various minority groups in the U.S. including African Americans (e.g. Lester, Artz, Resick & Young-Xu, 2010), Latinos (e.g. Barrio et al., 2008; Valdez, Dvorscek, Budge & Esmond, 2011), Asian-Americans (e.g. Kim et al., 2011), older women (Pieters, Heilemann, Grant & Maly, 2011), rural populations (e.g. Chipp, Dewane, Brems, 2011), various religious groups (e.g. Wamser, Vandenberg, & Hibberd, 2011) and LGBT populations (e.g. Austin & Irwin, 2010; Stoddard, Leibowitz, Ton & Snowdon, 2011). The international literature includes studies of refugee status (e.g. Inhorn & Serour, 2011), immigrant status (e.g. Dias, Gama, Cortes & Sousa, 2011, Ferayorni, Sinha & McDonald, 2011), and language related barriers to care (Cordasco, Ponce, Batchel, Traudt & Escarce, 2011; Lebrun & Dubay, 2010; Shi, Lebrun & Tsai, 2009). Access to care for specific mental health diagnoses have also been explored including studies on access for those presenting with anxiety disorders (Chartier-Otis, Perreault, & Belanger, 2010), depression (Ojeda & McGuire, 2006), eating disorders (Becker et al., 2010; Escobar-Koch et al., 2010), Alzheimer's (Franz et al., 2008), PTSD (Lester et al., 2010), alcohol use (e.g. Oleski, Mota, Cox & Sareen, 2010), and suicidal

ideation (Bruffaerts et al., 2011). Finally, across the aforementioned literature, research addresses structural impediments to care including cost of care, communication about available resources, lack of health insurance, appointment wait time, efficiency of referral systems, transportation, location of resources and culturally competent care (e.g. Chartier-Otis et al., 2010; Franz et al., 2010; Ferayornia, Sinha & McDonald, 2011; Mulvale & Hurley, 2008). This literature paints a complex picture of access to care for minority groups. Often, but not always, minority groups are found to underutilize care provided by the majority culture and to terminate treatment earlier. A thorough review of the literature reveals many rationales for the differences between minority use of services and the use by the majority population.

Ronald Anderson's model of help seeking behavior is among, if not the most, often cited in help-seeking literature and provides a useful framework to understand the complex processes involved in help-seeking (1995). The aforementioned literature, understood through Andersen's model, tends to focus on the domain Andersen calls "Primary Determinants of Health Behavior," which include population characteristics, characteristics of the health care system and external environmental factors. Research on primary determinants of health behavior is useful in planning and informing policy for the studied groups (Chartier-Otis et al., 2010). Focus on structural factors (transportation, communication about services, location of services etc.) and an understanding of community and psychological factors (beliefs about mental health care, stigma, alternative treatments, etc.) may help policy makers and helping professionals more effectively and efficiently reach and serve traditionally underserved populations (Ojeda & Bergstresser, 2008).

Some of the above-mentioned literature also addresses what Andersen calls, *Health*

Behavior, the outcome of the interaction of the primary determinants of health behavior (e.g. what does the individual actually do? Does he seek and/or access care?; e.g. Chartier-Otis et al., 2010; Ojeda & Bergstresser, 2008). Some of the literature begins by identifying those with unmet need, those who never accessed care or reported dissatisfaction with care, and proceeds from there to identify specific barriers (e.g. Bruffaerts et al., 2011). Some of the literature also touches on Andersen's third theoretical domain: *Health Outcomes,* the outcomes of the care and how those outcomes are perceived by the individual. The proposed study will address these help-seeking issues for a little-researched population that has been identified as underutilizing traditional mental-health resources using a qualitative approach. It touches on Andersen's three domains of help-seeking: Primary Determinants of Health Behavior, Health Behavior and Health Outcomes (specifically the sub-domain of Evaluation).

Qualitative methodology is particularly well-suited for unpacking complex issues and allowing the complexity of intersectionality of identities and environmental interaction effects to emerge (Charmaz, 2006). The proposed study will use grounded theory, a qualitative methodology that emphasizes the value of allowing theory to emerge directly from the data (as opposed to the researcher pre-supposing theory). Through the use of this method, I will explore the complexity of the process of help-seeking for immigrant Ultra-Orthodox, English-speaking Jews, a group with a unique and complex intersection of identities.

Research Questions:

Grounded theory is guided by research questions and also allows for the questions themselves to change as participants' stories inform the process. This study began with many

questions about *what* people in the community were doing and quickly developed into the more process oriented question: *How* do people in this community get help? What is the *process* this population is using to make help-seeking choices and decisions? These question became the focus of the study and guide the Results and Discussion sections of this document. In addition to the overall process question, this research addresses the following questions:

1. What are the messages individuals in this population hear about where to go when they are experiencing stress? How do these messages impact the help-seeking process?
2. How are people accessing resources? Which resources are most and least helpful?
3. How is help-seeking facilitated or impeded for this population?
4. How do people evaluate the success or failure of a help-seeking attempt? What factors do people report as important in meeting mental-health needs?

I have spent the past ten months interviewing and coding people's unique answers to these questions. What I have discovered is only a beginning to understanding the complexity of how individuals in this population seek help. What follows is an in-depth analysis of 26 interviews with English-speaking, Orthodox Jews living in Israel, stories of deeply stressful times and the help-seeking process that followed.

My intent is that this study will add to the literature on help-seeking behaviors and access to care among minority populations, adding a unique and under-studied cultural and religious group to the existing body of knowledge. This research also provides useful knowledge and insight for mental health providers seeking to work with this sub-section of Israeli society, a diverse and segregated society with unique and complex mental health needs (Ponizovsky, Geraisy, Shoshan, Kremer, & Smetannikov, 2007). The study also adds to the

body of literature on Orthodox Jews and to the literature on the process clients undergo before they enter the therapeutic relationship, a little-studied, yet potentially important part of the therapeutic process.

Chapter 2: Review of the Literature:

Help-Seeking Models, Access to Care, and Jewish Populations

Help-Seeking Models

The field of medical sociology has contributed several models of help-seeking that are used to understand how individuals seek and access mental health, in addition to traditional medical health, resources (Chartier-Otis, Perreault & Belanger, 2010; Ojeda & Bergstreser, 2008). These help-seeking models provide categories of psychological, social and structural variables that can impact whether an individual seeks and ultimately receives health care. The models also provide some theory about the extent to which each of these variables impacts actual received care (Andersen 1995; Mechanic 1962). Mechanic (1962) and Andersen (1995) proposed two of the foundational and most often cited help-seeking models in the psychology literature today (Ojeda & Bergstreser, 2008). Andersen's model provides an inclusive and chronological framework, while Mechanic emphasizes some of the psychological underpinnings of help-seeking behavior.

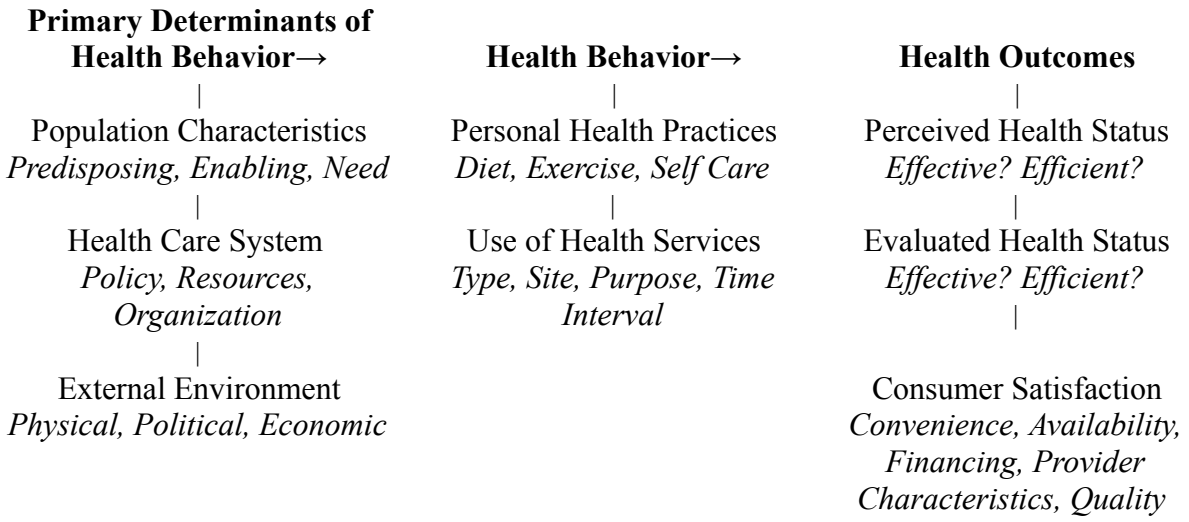
Mechanic: "The Concept of Illness Behavior." Mechanic (1962) focused on individuals' perceptions of illness and the impact of these perceptions on outcome *(whether* the individual seeks and finds treatment). He defines "illness behavior" as, "the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon by different kinds of persons" (p. 189). He notes that symptoms are only as important as the individual's interpretation of them; some will "shrug off" the same symptoms that will send others to immediately seek medical care. This illness behavior, he suggests, lies both conceptually and chronologically between etiology and treatment.

Illness behavior in this model is influenced by a variety of norms, values, fears and

expected rewards and punishments for behavior. Mechanic explains that illness behavior is largely accounted for by whether the adoption of a "sick role" is consistent with an individual's social setting and position within the social group. He suggests that gender, race-ethnicity and socioeconomic variables constitute salient markers of social role and status. Ultimately, the interaction of salient identities and resulting internalization of values influences decision; if the "sick role" is consistent with an individual's social setting and position and/or the need is great enough, a decision will be made to seek treatment.

Andersen's behavioral model. The Andersen model (1995; See Figure 1), originally developed in the 1960s, provides three sequential categories: (a) *primary determinants of health behavior*, which lead to (b) *health behavior*, which, in turn, lead to (c) *health outcomes*. *Primary determinants of health behavior* include population characteristics, subdivided into (a) *predisposing factors* (e.g. gender, age), (b) *enabling factors* (e.g. geographical location, income) and (c) *need factors* (including the severity of the disorder for which help is sought, level of distress, and duration of symptoms). Also included in the *primary determinants of health behavior* category are the health care policies, resources and organizations the individual has access to as well as his or her external environment (physical, political and economic components). *Health behavior* is divided into *personal health practices* (diet, exercise, self-care) and *use of health services* (type, site, purpose, time interval). Finally, *health outcomes* include (a) *perceived health status*, (b) *evaluated health status* and (c) *consumer satisfaction* (convenience, availability, financing, provider characteristics, quality).

Figure 1. Andersen's Behavioral Model of Help-Seeking (Andersen, 1995, p.7)



Andersen's model has been criticized for neglecting social networks, social interactions, and culture (Guendelman, 1991; Portes, Kyle & Eaton, 1992). Andersen responded to these criticisms by arguing that these factors are accounted for in the *population characteristic* components of predisposing factors, enabling factors and need, including perception of need (Andersen, 1995). Mechanic (1979) criticized Andersen's behavioral model for not adequately addressing the importance of health beliefs.

Health beliefs are attitudes, values, and knowledge that people have about health and services. They provide one means of explaining how social structure might influence enabling resources, perceived need and subsequent use (Andersen, 1995; Mechanic 1979). Andersen implies that health beliefs are only important as they directly impact perceived need. He acknowledged the importance of health beliefs, but argued that more precise measurement is needed to fully understand the impact of this construct (Andersen, 1995). Mechanic's model, which provides theory for how health beliefs become decisions, provides a useful complement to Andersen's behavioral model. Andersen outlines a clear, linear

progression of behavior and underlying factors, while Mechanic elaborates on the psychosocial process that underlies perceived need.

In the conclusion of Andersen's 1995 article explaining the development of his model, he outlines an "emerging model." This model hypothesizes that the process may not be as linear as he originally proposed. People do not seek care only once; health outcomes may not be a "final" phase, but rather one in a cycle, affecting population characteristics such as health beliefs, perceived needs and even enabling factors (the individual may now have more connections and resources than the last time he or she sought care). Individuals' experience also has the potential to impact community perceptions of care over time.

Variables Affecting Help-Seeking and Access to Care:

Minority Status, Religion, Gender, Psychosocial Barriers, Attachment, Therapist Match and Culturally-Competent Care, Immigrant Status and Jewish Identity

The following is a summary of the access to care and help-seeking literature focused on the domains most salient for English-speaking, immigrant Othodox-Jews living in Jerusalem: minority status, religion, gender, psychosocial barriers, attachment, therapist match and culturally-competent care, immigrant status and Jewish identity. This summary includes research from the United States, England, Australia and Israel.

Minority status. Research on mental health disparities in the United States shows that persons from racial-ethnic minority groups have less access to mental health care, engage in less treatment and receive poorer-quality treatment than non-Hispanic whites (Shim, Compton, Rust, Druss, & Kaslow, 2009). A review of the literature brings to light the complexities involved in this disparity. For some groups stigma plays a substantial role, for others structural barriers appear to be more salient. In each case, beliefs about mental-health

and help-seeking behavior interact in a way unique to each minority group studied.

Shim et al. (2009) analyzed data from the National Comorbidity Survey Replication (NCS-R) to help clarify barriers underlying the mental-health resources disparity. This study explored African American and Latino participants' willingness to seek treatment. Surprisingly, they found that, although African American participants were less likely to seek care, they reported more willingness to seek treatment and less embarrassment if others discovered they were in treatment when compared to Caucasian respondents. These findings were consistent even after analyses adjusted for socioeconomic variables. Latino participants similarly were found to have more willingness to seek treatment and less embarrassment if others found out they were in treatment than Caucasian participants. These findings, however, did not persist when analyses adjusted for socioeconomic variables. This research highlights both that generalizations can not be made from one ethnic group to another and that socioeconomic factors are an important variable in understanding willingness to seek treatment and embarrassment about doing so for some groups. It also suggests that for these minority groups, structural more than attitudinal barriers to care should be prioritized by policy-makers and helping professionals.

Lester, Artz, Resick and Young-Xu (2010) explored the issue of dropout and treatment outcome among African Americans being treated for PTSD. They found that African Americans were less likely to complete treatment compared with Caucasians (45% vs. 73% respectively, $p < .001$). Despite the drastic difference in dropout rates, treatment outcome was not significantly different between the two groups; both African American and Caucasian study participants appeared to have similar levels of symptom reduction. The authors used archival data and thus did not have data suggesting why the difference in dropout was so

dramatic. They hypothesize that African American participants' beliefs about treatment may include the belief that once symptoms are no longer troubling, treatment is over (i.e. they did not feel bound to complete the study treatment) and/or that the dropout may have been due to lack of culturally competent care. Although symptoms were reduced, perhaps the African American participants did not feel comfortable in the therapeutic relationship or because they were uncomfortable, dropped treatment as soon as symptom reduction occurred.

The above mentioned studies are examples of some of the complexities of help-seeking for minority populations; in both studies, researchers' hypotheses (first that there would be greater stigma in the minority communities and next that significantly different dropout rates would equal a significant difference in outcome) were disconfirmed. These studies are examples of how health beliefs of a minority population influence help-seeking behavior as well as outcome. The research is clear that each minority status is unique and should be individually explored, not making generalizations across minority groups (Becker et al., 2010).

Religion. Religious factors have been identified as part of an individual's perception of illness (Levkoff et al., 1999). Religious factors may be a salient demographic characteristic not only as a minority status, but also for the religious majority in a culture. Two religious coping styles have been theoretically proposed as particularly important in determining help-seeking across various religious groups: deferred coping, which involves the expectation that G-d[1] will intervene and solve problems (Pargament et al., 1988) and

1

It is customary in Orthodox Judaism not to write out any name of G-d as Jewish Law requires that any document containing such a name must be disposed of separately from other garbage and must be buried.

deistic coping, which assumes that G-d has given individuals the ability to solve their own problems (Phillips, Pargament, Lynn & Crossley, 2004). For those individuals with high levels of deferred coping, G-d is perceived as a form of support, so religious rather than psychological treatment will likely be preferred (Pargament et al., 1988). Individuals with high levels of deistic coping may perceive that they are solely responsible for their lives; for them G-d is not necessarily a source of assistance. Higher levels of deistic coping, therefore, may lead to an increased willingness to seek psychological rather than religious treatment. Pargament et al. (1988) note that individuals' help-seeking is likely correlated with degree of adherence to religion and religious fundamentalism.

Religion has also been shown to affect well-being of individuals undergoing stress including PTSD (Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003). Prayer has been noted as an effective coping strategy for stress (Wamser et al., 2011). In a survey study, Lowenthal & Cinnirella (1999) found that among Christians, Jews and Muslims, prayer was perceived as a more effective intervention for depression than medication and psychotherapy. Religious communities have also been noted as resources in times of stress and as points of access to care (Wamser et al., 2011).

A study out of Australia comparing mainstream religion (i.e., Christianity, Judaism and Islam), alternative religion (e.g. New Age spiritual belief and Paganism) and no religion revealed that 70% of the overall participants reported that they would like their belief systems taken into account by professionals such as counselors, psychologists, and psychiatrists (Smith & Simmonds, 2007). Those ascribing to a traditional religion noted an overall preference to seek spiritual guidance before seeking other forms of treatment. This research indicates that it is likely that those within religious communities are likely to exhibit

different help-seeking behaviors than those without this point of access to care, religious coping strategies and counselor preferences.

Gender. Women tend to seek services, both medical and mental-health, more than men; this finding appears to be consistent across a number of racial and ethnic groups in the United States including African American, Latino and Caucasian (Ojeda & McGuire, 2006; Wamser et al., 2011). A study of individuals seeking care for depression found that 73% of women self-reporting "poor health" were utilizing some form of care, compared to 50% of men. The same study found that 49% of older women (age 65 and up) reported some use of care, compared to only 26% of same-aged men (Ojeda & McGuire, 2006).

Franks and Medforth (2005) found that in a survey of help-lines, most reported that approximately two-thirds of the callers were female. A help-line for young Muslims was an outlier with a ration of 50/50. This finding challenges the literature which overwhelmingly reports males as having difficulties in negotiating pathways to help and suggests the importance of culturally-specific research to inform help-seeking literature for minority groups.

Koopmans and Lamers (2007) looked at mediating factors that may be causing differential use of medical healthcare in the Netherlands. They found that though men and women reported relatively equal propensity to seek care, they differentially reported mental distress and somatic morbidity. The difference in experience of mental and/or somatic distress, they propose, is the mediating factor causing women to seek help more than men.

Psychosocial Barriers. "Psychosocial barriers to care" refers to the development of characteristics or attitudes through interaction with a social environment. Ojeda and McGuire

(2006) list (a) stigma avoidance, (b) negative attitudes toward treatment and (c) fear or mistrust of healthcare systems as important psychosocial barriers to care to consider when investigating barriers to care for minority populations.

Stigma avoidance. Link and Phelan (2001) provide a four-stage definition of stigma. First, categories are established to differentiate people; these categories are assigned labels. Second, negative attributes are associated with particular labeled groups. Third an "us" versus "them" dichotomy is established. Finally, individuals associated with denigrated groups experience discrimination and status loss. Opportunity and social status are jeopardized when groups become stigmatized.

Internalization of stigma has been noted as an important factor in help-seeking behavior (Thoits 1985; Thoits 2005; Vogel, 2007). Seeking mental health treatment from a provider could represent unwanted confirmation of a stigmatized status. Thus stigma avoidance may be a significant barrier to seeking mental health. A study using data from the 2002 National Survey on Drug Use and Health found that, among adults aged 18 or older with serious mental illness who received no mental health treatment in the previous year and perceived an unmet need for treatment, 28.2% identified sigma-related items among reasons for not seeking care (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, SAMHSA, 2003).

Vogel et al. (2007) draw a distinction between public and self-stigma. They found that perceptions of public stigma contributed to the experience of self-stigma, which, in turn, influenced help-seeking attitudes and eventually help-seeking willingness. Self-stigma mediated the relationship between public stigma and help-seeking behaviors.

The research is mixed on the degree to which stigma impacts help-seeking behavior.

Corrigan (2004) suggests that stigma may be the single most common reason for not seeking mental health services. Although the evidence for the impact of stigma on help-seeking behavior is quite strong, this may be different for different ethnic and religious groups or specific diagnoses. For example, in an international sample of those with suicidal ideation, only 7% endorsed stigma as a reason for not seeking treatment (Bruffaerts, 2011).This may indicate that level of distress, for some groups, is a stronger help-seeking factor than the barrier of stigma.

Negative attitudes toward treatment. Kessler et al. (2001) found that 55% of National Comorbidity Study respondents with severe mental illness reported that they did not believe they had a problem requiring treatment. Others in the same study reported a perceived need but simultaneous belief that they should try to solve the problem on their own. Those with lower education or income have been found to be less likely to pursue professional assistance. One interpretation of these findings is that individuals of lower socioeconomic status are also more likely to have negative attitudes toward professional treatment (in addition to structural barriers; Thoits, 2005). Bruffaerts et al. (2011) reported lack of perceived need as the most important reason for not seeking help (58%), followed by attitudinal barriers such as the wish to handle the problem alone (40%).

Mistrust or fear of system. Mistrust of medical or mental health services can also deter help-seeking, willingness to return for follow-up care, and compliance with treatment recommendations (Thom, Hall & Pawlson, 2004). Mistrust of medical systems has been studied primarily in African American communities. Racial and ethnic discrimination within the health care systems has been identified as a source of mistrust or fear (Brown, 2003).

Structural Barriers. In a recent study of barriers to treatment for anxiety in the

United States, the most commonly reported barriers to treatment were concern about the cost of services (63.9%), lack of knowledge about where to go to get help (63.2%), lack of health insurance coverage (52.4%) and appointment wait times (52.1%). Inefficiency of referral systems and lack of communication and coordination between care providers have also been noted as significant barriers, particularly for individuals who are severely psychologically and/or cognitively impaired (Franz et al., 2010). Lack of clinicians who meet the language needs and/or cultural competency to serve a specific population are also cited as common barriers to care in the literature (Cordasco Ponce, Gatchell, Traudt, & Escarce, 2011; Levkoff, et al., 1999).

In a meta-analysis of research on barriers to access for family treatment, Snell-Johns, Mendez, and Smith (2004) provide the following list of research-supported methods for overcoming barriers and decreasing attrition: (a) offering transportation, child care, and low-cost services; (b) using the telephone; (c) providing home-based services; (d) facilitating self-directed and video-based interventions; and (e) using the format of multiple family groups. These findings indicate that significant barriers to care for families include transportation, child-care, cost, and time and hassle of getting to clinic.

Esccobar-Koch et al., 2010 compared help-seeking behaviors in the US and UK for individuals with eating disorders. In the UK, lack of, and inequity of, services were highlighted. In the US, the main concerns involved lack of financial accessibility to services and problems with insurance coverage. These findings about financial concerns and insurance coverage as significant barriers to care in the US are consistent across the literature for various ethnic groups as well as psychiatric diagnoses (Bruffaerts et al. 2011; Chartier & Otis et al., Cordasco et al., 2011, 2010; Levkoff et al., 1999, Snell-Johns, Mendez, and Smith

2004).

Attachment. Attachment theory dictates that attachment systems are activated when a person is under stress (Bowlby, 1973), and the activation of insecure attachment systems has been suggested to either inhibit a person from seeking appropriate help (Florian, Mikulincer, &Bucholtz, 1995) or interfere with a person's ability to use the help when it is present (Coble, Gantt, &Mallinckrodt, 1996). Sarason, Pierce, and Sarason (1990), for example, suggest that relationships with early caregivers affect the expectations people have concerning the level or type of support they would receive if they sought help in times of need. These expectations can then lead individuals who have had bad experiences to avoid disclosing problems to others. Consistent with this, insecure attachments have been shown to lead to less support-seeking behavior, particularly in times of stress or when the individual's anxiety is high (DeFronzo, Panzarella, & Butler, 2001; Florian et al., 1995). It seems that attachment avoidance may hinder a person from seeking counseling, whereas attachment anxiety may facilitate the use of counseling.

Vogel and Wei (2005) explored the mediating factors of perceived social support and psychological stress to better understand the complexities of adult attachment and the decision to seek psychological services. Structural equation model results indicated that attachment anxiety in individuals was positively related to acknowledging distress and to seeking help. Individuals with attachment avoidance, however, denied their distress and were reluctant to seek help. Both individuals with attachment anxiety and individuals with avoidance perceived less social support than securely attached individuals, which contributed to their experience of distress, and their distress then positively contributed to their help-seeking intention. Attachment anxiety and avoidance, social support, and distress explained

17% of the variance in intent to seek help. Vogel el al. conclude that, "even though these initial links between attachment and help-seeking have been examined, additional research is needed to confirm these results and to explore how the quality of attachment contributes to the help-seeking process beyond these direct relations."

Therapist match and culturally competent care. If a person chooses to seek traditional mental health services, another important factor in the help-seeking process is the availability and clients' perception of the availability of culturally competent care (Levkoff et al., 1999). One important factor that may influence this perception is the availability of counselors that match clients on salient identity factors such as gender, race, ethnicity, religion, and/or LGBT identity.

Coleman et al., 1995 conducted a meta-analysis of 21 studies of ethnic minorities and found that minorities did seem to prefer ethnically similar clinicians. Coleman notes however, that these findings for preference for an ethnically-similar counselor do not necessarily imply more positive outcomes. Some literature indicates that this preference does not affect outcomes. For example Flaskerud and Liu (1991) found that race and ethnic match between Asian clients and therapists had a positive effect on the number of sessions a client attended, but had no effect on client outcome. Liddle (1996) found that for LGBT identified clients, gay, lesbian and bisexual therapists of both genders and heterosexual female therapists were all rated more helpful than heterosexual male therapists. Therapist practices, however, accounted for more of the variance in ratings of helpfulness than did therapist demographic characteristics.

A recent meta-analysis (Cabral & Smith, 2011) confirmed individuals' preference for a therapist of their own race/ethnicity; the average effect size, Cohen's *d* was .63, indicating a

moderately strong preference for match. Individuals' perceptions of therapists were also more positive when ethnic match was perceived (d=.32). However the average effect size for outcomes for clients ethnically-matched with their therapists was d=.09, indicating almost no benefit of matching to treatment outcomes. Cabral and Smith found that effects of racial/ethnic matching were highly variable, mentioning specifically that African American participants demonstrated the highest effect sizes across preference, perception, and outcome. They warn against make generalizations across groups about the effects of client-therapist match.

Several studies have demonstrated that devoutly religious clients prefer to work with therapists who share in their faith or are religious (Weaver, Koenig & Larsen, 1997; Worthington, Kurusu, McCullough & Sandage, 1996). These studies note that clients may fear that nonreligious therapists will misunderstand or seek to undermine their beliefs. Worthington et al (1996) conducted a review of research consisting of 148 empirical studies. Among the results, was the consistent finding that highly religious Jews, Mormons, Protestants and Roman Catholics usually prefer counseling with religiously similar counselors and that highly religious Christians and Jews when they perceive a religious match are more likely to chose more intimate topics to discuss in therapy.

Overall, there is a trend in recent literature to focus on therapist skills rather than match. Liddle (1996) suggests that this trend may be a function of utility, noting that therapists cannot change their minority status to match a client, but can change skills and behaviors. Liddle (1996) also notes that clinicians, not clients are the intended readers of the peer-reviewed journals that these studies are published in; utility for clinicians, therefore, is an important publication consideration. However, she suggests that the results of matching

studies may be of considerable value to clients who are choosing a therapist. It is difficult to know if there are clients who never access treatment because they perceive there will not be a match. Little is known about how much racial/ethnic match affects a client's perception of the availability of culturally-competent care and how that affects help-seeking behavior; the literature is based only on those who are actively involved in a therapeutic process.

Immigrant status. Much of the current literature on immigrant status and help-seeking focuses on Latino and Asian populations in the United States. Epstein (2006) notes that barriers to help for immigrant Latina women in the United States include limited English language skills, fear of government agencies, lack of financial resources, social isolation, and restrictive immigration laws. Lack of knowledge about available resources and how to access resources is another barrier to care cited for the Latino population (Garcia, Gilchrist, Vazquez, Leite & Raymond 2011).

Chung (2009) notes similar barriers for the Asian population in the US, noting that "acculturation difficulties, inaccessibility to services and stigma associated with mental illness were major obstacles in the participants' help-seeking process." Chung is descriptive in her work about the "socio-cultural reality" of immigration, noting that immigration leaves individuals without familiar help-seeking pathways, often with impoverished support networks and coping mechanisms.

One study on immigration status in Israel and help-seeking appears in the literature. The study was conducted to look at somatization in recent immigrants from the Soviet Union. The findings included higher levels of somatic complaints for women and more complaints with longer length of stay in the country (up to 30 months of residence; Ritsner, Ponizorsky, Kurs & Modi, 2000). More somatic complaints and greater psychological

distress were correlated with greater incidence of professional mental health help-seeking.

Jewish populations:

Israeli demographics. According to Israel's Central Bureau of Statistics (2008), of Israel's 7.3million people (approximately 7.7 in 2010), 75.6% were Jews. Among them, 70.3% were Israeli-born, mostly second- or third-generation Israelis, and the rest were *olim* (Jewish immigrants to Israel), 20.5% from Europe and the Americas, and 9.2% from Asia and Africa (including the Arab countries). According to a 2010 study by the Israel Central Bureau of Statistics, of Israelis over age 18, eight percent of Israeli Jews define themselves as *haredim* (or Ultra-Orthodox); an additional 12% as "religious" (non-*haredi* orthodox, also known as: *dati leumi*/national-religious or religious zionist; 13% as "religious-traditionalists" (mostly adhering to Jewish law); 25% as "non-religious traditionalists" (only partly respecting Jewish laws), and 43% as "secular". Of the religious Jews, 66% of religious and 32% of haredi Jews have regular access to the internet (Central Bureau of Statistics, 2008; Central Bureau of Statistics, 2010). This may be a salient characteristic when considering points of access to care.

Mental health of religious Jews and help-seeking in Israel. Little is known about the help-seeking practices and barriers to care for the Orthodox population in Israel. A PsychInfo search for the keywords, "orthodox," "Israel" and "therapy" revealed only ten results. What is known is that Orthodox Jews in Jerusalem appear to underutilize public mental health services (Rosen, Greenberg, Schmeidler & Shefler, 2008). Rosen et al. interviewed 38 patients at Herzog Medical Center, a government-funded mental-health clinic in Northern Jerusalem. Rosen notes that the clinic's resources are underutilized by the religious population, which constitutes more than 50% of the population in this section of Jerusalem.

He draws the conclusion that this underutilization must be due to the stigma associated with mental illness, primarily quoting the Ultra-Orthodox marriage and dating system as the primary cause for such stigma (i.e. that no one would want to date someone who was known to be in treatment, or who had a close family member in treatment).

Rosen et. al's research reads very much like that of an outsider looking at an interesting cultural specimen. The research team clearly seeks to understand the group they study, but is limited by their outsider perspective. The 38 patients interviewed were all interviewed by the non-religiously affiliated psychiatrist they were seeing and other non-religious researchers and clinicians. In the limitation section, Rosen et. al acknowledge that their finding that even Ultra-Orthodox patients tended to give non-religious explanations to their mental illness may have been the result of impression management before a clearly non-religious interviewer.

The main findings of this research were that clinic utilization was significantly correlated to religious upbringing, but not necessarily to current state of religiosity. *Baalei teshuva,* those who became religiously observant but were not raised observant, utilized services more than those raised in religious observance. Younger *baalei teshuva* also endorsed significantly less stigma than older *baalei teshuva.* The researchers extrapolate that the reason for the underutilization of services is stigma, that those not raised religious were exposed to less of the stigma in the religious community and thus did not internalize it. They make no mention of the possibility that those raised in non-religious environments may simply be more comfortable in non-religious environments such as the clinic under study. They report asking about previous help-seeking behavior in their semi-structured questionnaire, but do not report any of the results. Although it is likely a contributing factor,

the authors fail to explore patients' (and potential patients') help-seeking behavior, leaving the question: does the Ultra-Orthodox population underutilize services, simply use different services (perhaps relying on their community more), or underutilize the Herzog clinic due to a range of barriers which may include stigma?

Shechtman, Vogel, and Maman (2010) also examined the issue of stigma toward mental health in Israeli society. Shechtman et al. studied the interaction of public stigma, self-stigma and attitudes towards seeking help in a population of 307 undergraduate students from three universities in the north of Israel. The majority of the students (n=235; 76.5%) were Jewish, and the rest (n=72; 23.5%) were Arab, representing what they report to be the normal ratio of students at the universities participating in the study. Ages ranged from 18 to 42 years (M=24, SD=3.92). The majority of the students (89%) were born in Israel. Just over half of all the students (54%) reported being secular and the rest reported being religious. They looked at the role of age, gender, college major and religious identity in relation to individual and group therapy. The study expected to replicate the findings of Vogel, Wade and & Hackler (2007) that endorsement of public-stigma would be positively correlated to self-stigma (internalized stigma), which would be negatively correlated to attitudes toward seeking individual or group psychotherapy. The Vogel study was conducted in the United States; Shectman et al. did not find the same results in Israel.

Shectman et al. found that public stigma may not be an important factor in the underutilization of individual or group treatment in Israel. One explanation they suggest for this finding may be that, in the studied sample, people formed their own opinion about help-seeking regardless of the opinions of others. This may be a result of living among a less conformist group of people or, alternatively, a lack of clear social norms as a result of living

in a highly immigrant society such as Israel.

In contrast to the stated hypothesis of the researchers as well as the aforementioned hypothesis of Rosen et al., public stigma was not higher in the collectivistic societies (e.g., Arab, Orthodox Jews). However, these two subgroups scored higher on self-stigma, which casts additional doubt on the supposition that self-stigma arises from the internalization of public stigma (Vogel et al., 2007) and suggests that public stigma may measure different constructs in different cultures. Moreover, intentions to seek help were higher among the collectivist participants (Arabs and Orthodox Jews) despite higher self-stigma. This research suggests a complex and somewhat counterintuitive relationship between stigma and help-seeking for Orthodox Jews.

There is also a significant body of literature exploring violence exposure and trauma in Israeli society. The only studies looking specifically at help-seeking behaviors related to trauma appear to be with adolescents (Gilat, Ezer & Sagee, 2008;Guterman, Haj-Yahia, Vorhies, Ismayllova & Leshem, 2010). Guterman et al. (2010) surveyed 1,835 Arab and Jewish adolescents living in Israel about exposure to violence and help-seeking behaviors. Findings indicated that only one in three Arab and one in four Jewish adolescents reported seeking help from anyone to cope with violence exposure-related stress. Gilat et al. also surveyed Arab and Jewish adolescents and similarly found that Arab youths were more willing to seek help, though not from public services. Guterman et al. found across both groups, subjects indicated that cognitive minimization of the event, deliberately maintaining the secrecy of the event, wishing to maintain their autonomy and failing to believe in the efficacy of seeking help from others were significant barriers to their seeking help. These studies make no mention of the religious identity of the youth involved. Although, these

results may not generalize to adults and the religious population, they do provide some useful information from large samples about youths' attitudes and beliefs about seeking help, primarily that minimization, secrecy, a desire for autonomy and failing to believe in the efficacy of seeking help from others are significant barriers.

Mental health of the Jewish population in the United States. Recent literature (Schnall, 2006; Tepfer, 2010) indicates that Orthodox Jewish individuals in the United States underutilize care. Schnall suggests that this may be due to lack of culturally competent care. As previously mentioned, religious Jews in the US have been found to prefer counseling with religiously similar counselors. A report published in 1985, found that 90% of Orthodox mental health professionals reported that the mental health needs of their community are poorly met (Feinberg & Feinberg, 1985). There is no evidence that secular Jews have a preference for Jewish counselors (Worthington et al., 1996). Tepfer (2010), in a dissertation exploring help-seeking behavior of Orthodox Jewish parents, found that help-seeking was significantly correlated to level of acculturation of the individuals studied; the findings also suggested that women tended to have more positive attitudes towards seeking services than men as well as higher rates of service use.

The NIMH Epidemiologic Catchment Area Study looked and incidence of mental health disorders and service use data over five years, collecting over 20,000 subjects. Yeung and Greenwald (1992) published the results of this study for Jewish Americans. Although the data is almost 20 years old and may no longer accurately reflect pathology and help-seeking behaviors of the Jewish population, it is interesting to note that there were significant differences to the general population. The findings indicated that Jews in the US did not differ from the general population in the overall lifetime rate of psychiatric disorder.

However, there was a significant difference between Jewish and non-Jewish samples when comparing the distribution of specific disorders. Compared with Catholics and Protestants, Jews had significantly higher rates of major depression and dysthymia but lower rates of alcohol abuse. Jews were more likely than Catholics or Protestants to seek treatment with mental health specialists and general practitioners. These differences remained statistically significant after adjusting for demographic factors (sex, age, race and socioeconomic status).

The purpose of the present study is to explore the help-seeking process and barriers to care for Orthodox, English-speaking, Jewish immigrants in Jerusalem. Research suggests that this minority population underutilizes mental health resources, though their intent to seek care may be comparatively higher than the Israeli general population (Schectman, 2010).

Chapter 3: Methods

Method Rationale

This study is a qualitative, constructivist grounded theory exploration using semi-structured inductive interviews. Qualitative research was chosen as a methodology because of its utility in accessing the richness of individual experience in the understanding of a phenomenon and the capacity for the researcher to observe and take into account contextual factors that may emerge as important only as the research progresses (Charmaz, 2006). Qualitative research is appropriate when the researcher seeks a detailed and in-depth view of a phenomenon. In qualitative research, the researcher seeks to understand the meaning that individuals make of their experiences. The process of achieving richer, more detailed data can assist with construct clarity and validity (Morrow, 2007). Grounded theory allows theoretical understanding of a phenomenon to emerge from the data itself, rather than necessitating a pre-conceived theory to be tested (Charmaz, 2006).

This is a particularly useful approach for understanding the process by which a minority group seeks mental health services, as very little is known about the sub-population to be studied, especially in relation to their mental health specific help-seeking behavior, access to care and overall experience (Rosen et al., 2008, Schechtman et al., 2010). Constructivist-grounded theory is a branch of grounded theory that assumes that theory does not lie in one reality, but that participants' multiple realities are important in constructing theory and that theory and knowledge are created equally by the researcher (the viewer) and the participant (the viewed; Charmaz, 2006).

Standards of Trustworthiness

Morrow (2005) described the phenomenon of "trustworthiness" as standards of

credibility for qualitative research that emerge from qualitative research itself and are not based on quantitative methods. Rather than using standards of evaluating research based on quantitative designs such as validity and reliability, Morrow discusses standards specific to qualitative research that reflect its theoretical underpinnings and provide methods to increase the rigor of these research designs; rather than using the term "validity," Morrow discusses "trustworthiness" as the measure of a good qualitative study.

Morrow (2005) proposes four transcendent criteria for qualitative research (transcendent here refers to being above/overarching and thus applicable to the full range of qualitative paradigms from radically constructivist to positivist): social validity, subjectivity and reflexivity, adequacy of data and adequacy of interpretation. She also notes the importance of acknowledging the co-construction of meaning in constructivist-based studies. I will briefly describe the criterion she outlines here as well as how each of the criteria are addressed in this study. More in-depth descriptions of the application of these criterion are included throughout the methods and discussion sections.

Social validity is a term Morrow borrows from Wolf (1978); it refers to a subjective measure of social importance. Although Wolf explains his criterion in a paradigm of behavioral research, it can be extrapolated to use in qualitative research. He discusses social importance as: (a) Are the goals of the research useful for the population studied? (b) Are the procedures socially appropriate ("Do the ends justify the means?") and (c) Is there social importance of the effects of the study? Is there practical application of the findings? The goal of this research is to generate theory about the process that English-speaking Orthodox Jewish individuals are using to access help in times of emotional stress. The procedure of the study is a consensual 20-30minute interview. The study was designed to have implications

for research, practice and community psychoeducation; these implications are presented at length in the discussion section.

Subjectivity and reflexivity refers to the researcher's intentional use and management of subjectivity. In contrast to forms of investigation that call on the researcher to be objective, qualitative research requires the intentional and theoretically situated use of subjectivity (Charmaz, 2006; Morrow, 2005). In a constructivist study, this includes acknowledging and using rather than "bracketing," acknowledge for the sake of setting aside, subjectivity and using it as a data source. Morrow emphasizes the importance of the researcher making her implicit assumptions and biases explicit to herself and others through reflexivity and representation. This area of trustworthiness was addressed in this study through making assumptions explicit in the research proposal, manuscript and the use of a self-reflective researcher journal (an ongoing record of my experiences, reactions, and emerging awareness of assumptions), use of a peer reviewer/co-researcher, external auditor, internal auditor, and the use of a participant check.

Adequacy of data includes: (a) adequate amounts of evidence, (b) adequate variety in kinds of evidence, (c) interpretive status of evidence, (d) adequate disconfirming evidence and (e) adequate discrepant case analysis (Erickson, 1986). These components of trustworthiness were addressed through (a) data collection until the point of saturation, (b) purposeful sampling, sampling with the explicit purpose to provide a variety of perspectives and saturate categories, (c) use of interviews as well as memos and researcher's acquired knowledge of culture and context and the interviewer's intention and focus on creating rapport to insure a level of comfort and honesty in the interview and (d &e) repeated immersion and re-immersion in the data to find and account for evidence that might

disconfirm the use of a focused or theoretical code. The internal auditor and co-researcher on the project also audited randomly selected interviews to check for any information that did not fit, or disconfirmed any part of the theory that emerged.

Adequacy of interpretation includes (a) immersion in the data, (b) use of systematic analytic framework, (c) use of analytic memos and (d) adequacy of participant evidence to support the researcher's emergent theory in the reporting of the findings. Immersion in the data includes repeated readings of transcripts, listening to recordings and review of memos (Morrow, 2005). An articulated analytic framework within which the data will be systematically analyzed is also a crucial part of adequacy of interpretation of the data. The framework, says Morrow, should spring from the overall research design selected at the beginning of the study. Analytic memos, a collection of hunches, interpretations, queries and notes made by the researcher from the beginning to the end of the investigation should also become part of the body of data and should be reviewed frequently for incorporation in to the analysis (Morrow, 2005). Also included in adequacy of interpretation is the strong backing of the investigator's interpretations by supporting quotations from participants. These aspects of trustworthiness will be discussed at length in the analysis section and a comprehensive list of codes with participant quotes is included in Appendices C-E (Charmaz, 2006; Morrow 2005).

Finally, Morrow emphasizes the necessity in a constructivist study to deeply understand participant meanings and how they are co-constructed with the researcher. This includes the researcher paying close attention to rapport, understanding the cultural context of participants and, again, the researcher's checking and re-checking of her assumptions. Morrow notes that rapport building comes easily to counseling psychologists and that in-

depth research into cultural context is necessary when the researcher is an "outsider." As a student in clinical psychology, I have studied and applied concepts of rapport building and did find, as Morrow suggests, that this skill came naturally to me. It also appeared quite natural to the male interviewer employed in the study. The difficulty in building rapport is one of the reasons that the female interviewer was not asked to conduct more interviews (this decision was also based on an emerging experiential understanding of the importance of the co-construction of meaning. The male interviewer was continually employed as a cultural sensitivity for men who preferred a male to conduct the interview). As an "insider" of the group being studied my emphasis was on checking and re-checking my assumptions; I did this through journaling, the use of a co-researcher, auditors and a participant check. The co-researcher and external auditor, who do not identify as in-group members, were particularly helpful in pointing out assumption and patterns that I missed because of my in-group status. I discuss this process in the analysis section.

Participants

In comparison to quantitative research designs, fewer participants are needed in qualitative designs in order to capture the meaning and experience that can be investigated through qualitative research (Morrow & Smith, 2000). Morrow & Smith (2000) wrote that sampling in qualitative research should occur to the point of "informational redundancy, where no new information is forthcoming despite continued interviews" (p. 218). Charmaz (2006) recommends that qualitative researchers avoid using larger samples because of the time needed to analyze the large amounts of data and because at some point additional cases typically add minimally new data.

Participants for this study were 26 English-speaking, Orthodox, or Ultra-Orthodox

Jewish Israeli immigrants (or those living for over two years in Israel; official immigrant or "*aliyah*" status was not a criterion as many English-speakers live in Israel long-term but for various political or financial reasons, do not attain resident or immigrant status); participants all live in Jerusalem, and were over the age of 18. Participants ranged in age from 21-65 with a mean age of 38.35 (SD=13.89); 13 are male and 13 are female. All participants had health insurance at the time of the interview. Participants' time living in Israel ranged from 2-37 years with and average of 13.06 (SD= 10.12); 16 were Israeli citizens and 10 were not. Most of the participants (*N= 21*) were originally from the US; three were from England, one from Canada and one was born in Hungary but spent most of his childhood in the United States. All participants were married at the time of the interview. Of the 26 participants, 10 identified as *baalei teshuva* (not raised religiously, became religious) and 16 identified as religious from birth. Snowball sampling was used to recruit participants beginning with the researcher's community contacts in Jerusalem, Israel. A chart with demographic information is available in Appendix A.

Researcher

Understanding of the social location of the researcher in relation to the study is essential to understanding the full context in which research is taking place (Morrow, 2007). In addition, according to Morrow, as the researcher makes public his or her own stances, motivations, assumptions and biases, the research gains a level of honesty that contributes to the trustworthiness and rigor of the study (2005).

I, the primary researcher, began this project as a fifth-year graduate student at a West Coast University. I identify as an in-group member to the population being studied (English-speaking Orthodox Jewish individuals living long-term in Israel). My interest in the study

was sparked through casual conversations I have had in the community; mothers asking me questions such as, "how do you know when a person needs therapy and when they're just going through a phase?" and phone calls from friends and students who are seeking mental-health services and did not know how or where to begin. I have worked for three and half years at a low-cost community clinic in Jerusalem and taught at an English-speaking master's program affiliated with the clinic. I have worked in the non-profit sector and am somewhat familiar with the community of therapists in private practice; I know little about government-funded clinics in the Jerusalem area.

My social location as an in-group member carries with it certain assumptions about the community in which I live. Beginning the research, I assumed that there is some degree of stigma associated with seeking professional help. The dating system in the religious community is formalized and it is expected that before going on a date each side will check the others' character references. Several young women I've worked with as clients have expressed not wanting anyone to know they are in therapy because they fear that this information may “cut out” potential dating prospects. Regardless of how true that might be, I have heard from them that this is a concern and so it is a bias I brought with me to this investigation. I also had a strong reaction to Rosen et. al's (2008) assertion that the underutilization of government resources by the religious population is primarily due to stigma. This assertion seemed an oversimplification of the issue, making no mention of possibilities such as transportation, lack of therapist-client match on cultural and religious backgrounds, and/or lack of knowledge about these services.

I have some experience in qualitative research; I conducted a qualitative study exploring the varied experiences of the California foster care system as part of a Masters in

Sociology through Stanford University. It was also a semi-structured interview format, although not specifically a constructivist grounded theory approach.

The secondary researcher was a second-year graduate student at the same West Coast University at the beginning of this project. She does not identify as an in-group member of the group being studied. She has experience working on one previous qualitative study. Her role was both as a collaborator and auditor. She coded every interview and was immersed in the data with me. We had regular research meetings via Skype ranging from once a month during initial, line-by-line coding, to weekly meeting during initial focused coding and theoretical coding. The secondary researcher both collaborated with me in allowing the underlying theory about help-seeking in this population to emerge as well as providing an outside perspective, checking the assumptions I carry as an in-group member.

Two additional interviewers were also employed; one male and one female. Because Orthodox men are not always comfortable being interviewed by a woman, they were given the option of speaking with a male interviewer. I trained the interviewers by demonstrating the interview procedure, having them listen to a recorded interview and finally having them role-play the interview with me. I listened to all of the interviews they conducted to assure that their information gathering was focused on the help-seeking behaviors of the interviewees and that their interviewing style seemed sensitive and appropriate. The female interviewer conducted two interviews; the male interviewer conducted four. I gave them feedback where it was needed. Both interviewers are in-group members of the population studied. As the semi-structured interview changed and theory emerged, they were informed and their input was incorporated into the emerging theory.

This study also employed an internal and external auditor (see procedure). The

internal auditor is a master's level clinician with an M.S.W. She considers herself an in-group member of the study population and was interested in helping a study that will help her and her colleagues better serve the community she lives and works in. The external auditor is a professor of counseling psychology at the same West Coast University as the primary and secondary researchers. She does not identify as part of the subject population and has extensive knowledge and experience with qualitative methods and research.

Procedure

Sampling. Snowball, or chain referral, sampling was used to recruit participants. Initial sampling excluded only participants who did not meet the criteria of living in Jerusalem, age, language, religious affiliation and/or length of time living in Israel (born outside of Israel and living in Jerusalem for over two years). Purposeful sampling was employed in order to ensure that certain demographics were represented (i.e. men working outside of the world of Jewish education). After distinct theoretical categories emerged through consensus (see Data Analysis), theoretical sampling, sampling with the goal to elaborate and refine the categories which emerged was used consistent with a grounded theory approach (Charmaz, 2006; Morrow 2005). This is consistent with the purpose of this study: to discover a theoretical framework to understand the process by which English-speaking, Orthodox individuals living in Jerusalem seek help in times of emotional stress. The proposal for this study estimated an N of 25 interviews and committed to continue to be collection until saturation had been reached (See Data Analysis). Twenty-six interviews were collected and the external auditor, a professor with experience in qualitative methods, consulted to confirm the researchers' experience of saturation of data.

Demographic Questionnaire. Each participant was asked to complete a demographic

questionnaire immediately prior to the interview along with informed consent. A questionnaire, rather than asking these questions as part of the interview was chosen at the suggestion of an experienced qualitative researcher (M. Morgan-Consoli, personal communication, February 7, 2012) who suggested that beginning with short answer questions, such as those seeking simple demographic information, might socialize interviewees to a short answer norm and pose a barrier to the collection of rich data.

Semi-structured Interview. The interview (see progression of interviews, Appendix B) began with what Spradley (1979) calls a "grand tour" question, a very broad opening question inviting the interviewee to describe the process in question in his or her own words before more specific or directed questions are asked. Brenner (2006) notes that a grand tour question is not appropriate for many situations. A new informant, she explains, typically seeks cues from the interviewer about what is expected during the interview, not only for content of the discussion, but also the length of response, depth of detail, and formality of language. Brenner supports the initial use of a grand tour question, but urges the interviewer to be willing to modify this opening question in future interviews if it seems that interviewees give more rich responses to more specific questions or questions with longer introductions. Participants responded quite differently to the grand tour question; some spoke for many minutes explaining their process and some, as Brenner suggests, needed more cues about how to structure their story. The grand tour question remained as the opening part of the interview but was managed differently according to the needs of each participant.

Three versions of the interview evolved through the course of the study; the interviews are included in Appendix B. This interview was allowed to evolve and change as interviews accrued consistent with Brenner's suggestion and the grounded theory idea that

data collection strategies should be allowed to change as simultaneous analysis informs the process (Charmaz, 2006). The differences included, changing the grand tour question from, "Think of a time you were under significant stress. Can you tell me about how you handled it and you decided to do what you did?" to "Think of a time you were under significant *emotional* stress..." This change was made after the third interview I conducted when I realized that I needed to focus participants on the emotionally stressful components of situations rather than focusing on the details of the stressful situation itself. For example, the third interviewee spent some time explaining exactly what a doctor told her to do (how, when, how much, etc.) until I re-focused her, explaining that I was interested in how that information affected the emotional stress she described. The second revision added the question, "What are the ideal steps a person should take to get help in a time of stress? (If you had to tell someone who looked up to you how a person *should* look for help, how would you respond?)" This question emerged as the result of a focused coding problem: the secondary-researcher and I agreed on a code, "perception of resources" to code participants' comments about characteristics of resources they mentioned. When I sent a list of initial focused codes to the external auditor she noted that this code seemed unclear, somehow not close enough to the data I had presented as examples of the code. Discussion of this feedback with the secondary researcher resulted in the emergence of the existence of a paradigmatic filter people were using that we began to code as "Working Model of Help-Seeking." I will discuss this code at length in the Findings section. The new question was added to make this underlying working model explicit.

Intensive inductive interviewing was employed; the researcher and interviewers used a semi-structured protocol and asked relevant follow up questions or gave relevant prompts

with the goal of in-depth, rich information about the full process of seeking emotional support and/or services. The interviews were 15-30 minutes long and conducted at a place convenient for the participant. All interviews were conducted in English, and were audio recorded and transcribed. Interviewees were given 50 NIS (Israeli Shekel) for their participation (approximately $12).

Memos. Consistent with the standards of trustworthiness Morrow (2005) calls "adequacy of data" and "adequacy of interpretation," detailed memos were kept throughout the data collection (as part of a reflective journal) and data analysis (in the form of memos). Charmaz (2006) calls memo writing, "the pivotal intermediate step in grounded theory between data collection and writing drafts of papers." Memos included impressions of individual participants, emerging ideas about the process of help-seeking, analysis of my own assumptions, hypotheses and descriptions of possible categories and other useful notes and observations that guided my analysis. These memos are both part of the analytic process and a piece of data unto themselves (Charmaz, 2006). Immersion in the data included not only a thorough review of the interview data, but also of the memos. I shared many memos with the co-researcher during research meetings, especially those focused on theoretical coding.

Research Questions

In order to allow theory to emerge about help-seeking behaviors in the English-speaking Orthodox Jewish community living in Jerusalem the following research questions were initially formulated:

1. What are the messages individuals in this population hear about where to go when they are experiencing stress?
2. What resources are people accessing?

3. Are there resources people would like to access and are unable to?/ Barriers to care?

4. Are the resources being accessed meeting individuals' mental-health needs?

As the research progressed, an overarching research question emerged: What is the *process* this population uses to make help-seeking choices and decisions? This question became the focus of the study and guides the Results and Discussion sections of this manuscript. The other research questions, formulated initially to guide the interviews, became more process oriented, more "how..." rather than "what..." questions as a result:

1. What are the messages individuals in this population hear about where to go when they are experiencing stress? How do these messages impact the help-seeking process?

2. How are people accessing resources? Which resources are most and least helpful?

3. How is help-seeking facilitated or impeded for this population?

4. How do people evaluate the success or failure of a help-seeking attempt? What factors do people report as important in meeting mental-health needs?

The initial research questions are addressed in the Discussion section as well as the more process-oriented questions. However, the focus of the study as theory emerged, became much more focused on answering the latter set of research questions.

Data Analysis

A constructivist grounded theory approach (Charmaz, 2006; Strauss & Corbin, 1990) was used to analyze the interview transcripts. Grounded theory is an inductive methodology intended to generate theory from narrative text coded into descriptive categories. Constructivist grounded theory refers to a philosophy underlying the methodology that acknowledges that the resulting theory is an interpretation; it views both data and analysis as created from shared experiences and relationships with participants and other sources of data

(Charmaz, 2006).

Data was systematically coded and compared in order to create conceptual categories and identify their properties as well as the relations among them (Creswell, 1998). The analysis happened in three phases: line-by-line coding, focused coding and theoretical coding.

Line-by-line coding. First, a line-by-line analysis was conducted for initial interviews by two independent coders trained in grounded theory methodology. Line-by-line coding encourages the researcher to take a detailed look at the data allowing for nuances and subtleties to emerge which may be missed by looking at larger chunks of data. This is suggested as an initial form of data analysis as it is detail-oriented and may help to re-focus later interviews but is also very time consuming. Charmaz suggests that this method of analysis be used until themes/categories begin to emerge (2006).

Three interviews were coded line-by-line by both researchers. A research meeting was held after the second and third interviews were coded. Charmaz (2006) suggests to code as much as possible in gerunds ("searching," "asking," "trying," etc.) in order to have codes stay closely connected to the story of the participant. In accordance with this suggestion, both researchers tried as much as possible to code in this manner. A comprehensive list of these codes is included in Appendix C.

Focused Coding. Focused coding involves "using the most significant and/or frequent earlier codes to sift through large amounts of data. Focused coding requires decisions about which initial codes make the most analytic sense to categorize your data incisively and completely" (Charmaz, 2006, p. 57). This process is inductive and allows for the researchers to discover patterns from the data.

After comprehensively coding three interviews line-by-line, the researchers agreed that themes were beginning to emerge. Each researcher individually created a list of focused codes. At this point we met, shared codes and rationales, resolved discrepancies, and agreed on an initial set of focused codes to facilitate consistency in the coding process. We then re-coded the three interviews that were coded line-by-line. In a separate meeting, we reviewed the "goodness of fit" of our focused codes and addressed any text that did not fit into a code. In these instances we either re-defined a pre-existing code to be broader and more inclusive or added a new code. Interim meetings were conducted to discuss any coding difficulties, as well as discuss emerging themes. A set of initial focused codes was sent to the external auditor (see Appendix D). She confirmed that the codes were clear and accounted for the data presented with the exception of one code, "Perception of Resources." This code she found unclear and not close enough to the data presented as evidence of the category. This feedback resulted in the new code, "working model of help seeking," and the addition of the question, "What are the ideal steps a person should take to get help in a time of stress? (If you had to tell someone who looked up to you how a person *should* look for help, how would you answer?)" to the original interview.

Theoretical Coding. Finally, meetings were held for theoretical coding. The process of theoretical coding involves conceptualizing how the substantive codes relate to each other; it is the process of synthesizing the categories which emerged during focused coding into a coherent theory of the process in question (Charmaz, 2006). At this point, when distinct themes emerged, interview subjects were chosen who appeared likely to help the researchers clarify and better understand a particular pattern. Data were collected until saturation was reached. Charmaz (2006) defines the point of saturation as the point, "...when gathering fresh

data no longer sparks new theoretical insights , nor reveals new properties of your core theoretical categories." The external auditor, a professor of counseling psychology experienced in qualitative research agreed to consult on the issue of saturation. When the primary and secondary researcher agreed that saturation was met, the primary researcher consulted, sharing the rationale for stopping the collection of data.

At this point, a written explanation of the categories that emerged from the focused coding and the theory that emerged were delivered to the internal and external auditor for review (Appendices E and F). Participants were also sent (by email, mail, or hand delivery) a summary of the results and asked to fill out a questionnaire for feedback (Appendix F). Three participants were contacted by telephone to clarify the information they shared. This type of participant-check is explained by Charmaz (2006) as a way to refine categories and understanding. After looking into other methods of participant-checks (e.g. sending copies or transcripts, focus groups) this method appeared to be the most time-efficient and practical for the population being studied.

Both the focused coding scheme and theoretical framework that emerged from theoretical coding were audited by an internal auditor familiar with the population being studied and an outside auditor familiar with grounded theory and the study but who is not involved with the population studied. The internal auditor was given five randomly selected interviews and was asked to check that the raw data was represented by the focused coding scheme in an understandable and logical way. The selection of five random interviews was a consideration of time for the internal auditor. The internal auditor verified that the codes matched the raw data. Next, the internal auditor reviewed the theory that emerged from theoretical coding and checked to see that the raw data in the five selected interviews was

consistent with the theory. Again, she confirmed that the theory fit the data and seemed culturally sensitive.

The external auditor received a written explanation of the focused coding categories with representative quotes from relevant interviews as well as a description of the theory that emerged from the coding. She primarily focused on the research methods used and the logical coherence of the resulting theory. The external auditor noted some redundancy in the focused codes and helped the researchers to sharpen the definitions of codes to avoid this redundancy. The use of auditors is suggested by Elliot et. al (1999) in their guidelines for publication of qualitative research, as a demonstration of rigor and as a check for researcher bias.

Participant Check

Of the 26 participants, 22 agreed to receive a summary of the study's findings and participate in feedback. Eleven participants returned the feedback form (Appendix F). All participants reported that they felt one of the three types of help-seeking filters described them. Seven participants marked that the nine-stage help-seeking process described their experience "accurately," three that the model described their experience fairly accurately and one that it fit moderately. Collecting the forms via email, phone and sometimes in person, participants often commented that they found the interesting findings their favorite part of the feedback form and found most of the other findings somewhat academic and less interesting.

Chapter 4: Results

This chapter focuses on the results of the theoretical coding. The focused coding, although an integral (and time-consuming) part of the analysis, was a means to allowing theory to emerge from the data. The focused codes are addressed briefly in this section and at length in the appendix. The theory described in this section incorporates some of what might traditionally be presented in a discussion section; where it was helpful to explain or clarify some part of the results, I incorporated supporting literature or made reference to similarities or differences with research mentioned in the literature review. The discussion section focuses primarily on implications of the theory that emerged and includes a more comprehensive assessment of implications for research.

Results of Focused Coding

The final list of focused codes included: Response to Stressor (external response, internal response, and first response), Description of Stress, Working Model of Help-Seeking, Self-Perception, Barriers and Facilitators (environmental barriers, internal/intrapersonal barriers, facilitators), Resources (available, unavailable), Perception of Helper (helpful, unhelpful), and Evaluation. A comprehensive list of these final focused codes and quotes supporting these categories is available in appendix D.

Theoretical Analysis

The coding and audit process described above resulted in a nine-stage, cyclical feedback model of help-seeking with three distinct, attachment theory-informed, categories of help-seekers. A flow chart of the stages is available in Appendix E. The help-seeking stages are: 1: Emotional response to stressor, 2: Definition and classification of problem, 3: Help-seeking filter, 4: Help seeking decision, 5:(a) Seek external help, (b) Independently

manage stress, 6: (a) Barriers and facilitators to finding external help, (b) Barriers and facilitators to self-help, 7: (a) Help experience, (b) Self-help experience, 8: Evaluation and finally, 9: Re-definition of problem (or remaining problem). This final stage leads back to stage 1: Emotional response to stressor; if the emotional response to the newly defined problem is one of relatively low stress or of calm, the process will be followed until stage 5b: Independent Management of Stress, which contains the subcategory, "discontinue help-seeking process." If the remaining problem is still experienced as relatively stressful, the process will continue. Descriptions of each stage and substage are presented with examples below.

Stage 1: Emotional response to stressor. Within the focused code, "Description of Stress," and "Response to Emotional Stress: Internal," many participants explicitly noted a moment of acknowledging a threshold of emotional distress (Nancy: "It just got to be too much to be the person that was married with three children, having a job, dealing with siblings that needed emotional support, and dealing with my own emotional distress... at that point when I broke down in tears to my friend, it was because it was just too much." Rebecca: "It was a nightmare. I was so stressed out by it. I was at a point where I didn't know how to deal with it. It was too out of control;" Note: all quotes in this section are presented under a pseudonym.) For those who did not explicitly mention a distinct moment of reaching their threshold, most described the experience of a high level of emotional stress (Chanuch: "Things were swimming inside..."; Bracha: " When I found out that the kids had pinworms pretty recently, it was stressful because I get a little bit obsessive about cleanliness, or things that are contagious and stuff like that. Compared to other people's stresses, this might sound very insignificant, but for my type of personality, this is very significant."; Gitty: "I was

petrified. I was *mamash* [really]-- I don't remember ever being in such state of tension and fear over what's going to be. What's going to happen?... I don't know. I just went into this state of panic.") Participants identified (sometimes explicitly, sometimes implicitly in the chronology of their narratives) the emotional experience to be the initiating factor for the subsequent help-seeking process.

Stage 2: Definition and classification of problem. This stage was described by participants as a cognitive assessment and categorization of the problem or stress. This assessment was a key factor preceding the help-seeking decision. Participants described three main sub-categories of classification of the situation at hand: (a) the issue of confidentiality versus non-confidentiality, something they were versus were not worried about others knowing, (b) type of problem (primarily medical, psychological, interpersonal, and/or life decision) and (c) assessment of the severity of the problem.

The issue of confidentiality or privacy was mentioned frequently in interviews. For example, Gitty explained,

> "I know she's a safe person to talk to because she's in OA [overeaters anonymous] and we're very, very serious about our anonymity. I wasn't worried about it getting out there in the street or something...I'm pretty open about getting help. I think most people in the Haredi [ultra-orthodox] community are not. We're very secretive. We're always scared that something is going to effect our shidduchim[dating] or our name in the society that we're in...I used to be a lot more open about everything. I've closed up a lot more because I found that things come back and hurt me. Being too open wasn't good, either. I pick and choose my people nowadays a lot more than I used to."

Many participants discussed a general desire for privacy (Shmuel: "I guess one of the shortcomings of replacing the family support system with the neighbor/Kollel [learning group]/friends support system is perhaps that you are less open with them, and then you feel you could come to a situation where you feel people are prying on other people.") Other

participants described underlying beliefs that family matters stay within the family, that embarrassing someone should be avoided at all costs or that privacy, in general, is an admirable trait (Nancy Goldstein: "As it got more intense, I definitely spoke not really to friends, because it was a family thing that was private and something we wouldn't want to really publicize or share with anyone." Shoshana: "My mother says it all the time, 'Don't air your dirty laundry in public. You don't need other people to know your problems.'). An overall emphasis on confidentiality, the person reached-out-to keeping the information confidential, and/or privacy, not too many people knowing, was noted by both researchers in lists compiled separately of population-specific help-seeking characteristics and by the primary researcher in multiple analytic memos.

The type of problem (medical, psychological, interpersonal or life-decision) was described by participants as both a factor in the desire for confidentiality as well as a guide in how and what type of help to seek. This categorization was expressed most clearly in response to the interview question, "What are the ideal steps a person should take to get help in a time of stress? (If you had to tell someone who looked up to you how a person *should* look for help, how would you answer?)," added in the final version of the interview protocol. Some examples of responses demonstrating this categorization are:

> "It depends on the situation. If it's a very minor thing that I had some ability, that I could coach them along in the process...if someone comes to you, and just for an example, they have a problem with drinking or with drugs, I would probably immediately suggest professional help for that. It's well beyond my capabilities... If someone is having trouble in their marriage..." --Shmuel
>
> "It depends what the problem is. You can't be too... If it's a psychological problem, then you have to go to a psychologist, or someone who has a lot of life experience. It doesn't have to be a professional psychologist or psychiatrist. Now they have things they didn't have in my day- those life coaches, they might find somebody good in that area. They could probably

> help you....Sometimes the best thing is just to say forget it. Cut the rope and go on to the next thing. That might be your best answer. Maybe there is no solution..." --Nathan
>
> "I'm saying that it really depends on the problem. If someone has a real issue they would have to go to therapy, you know what I'm saying? A lot of issues now are like shilas, questions, 'what should we do?' We go to the Rav [Rabbi]. It depends on the problem, I think. It depends on the person's problem. For sure, seek help and depending on what type of help they would need, I would tell them where to go." --Rebecca

A problem classified as non-confidential, medical or life-decision oriented (although there are medical and life-decisions participants did classify as highly private) and severe were likely to elicit a decision to access outside resources. Problems participants described as confidential, psychological or interpersonal and less severe, were less likely to elicit a decision to access outside resources.

Assessment of severity of problem. This factor in problem categorization was often expressed as the cognitive awareness of the emotional response to stress (Stage 1), the point at which an awareness was reached about the level of discomfort being experienced. Again, this was most clearly expressed by those noting a distinct moment of reaching a threshold (Rebecca: "I was at a point where I didn't know how to deal with it. It was too out of control."). It was expressed by many participants as a general awareness of a high stress level (for examples, see Stage 1). Some problems that were not experienced as emotionally intense were assessed as severe due to the nature of a medical condition and/or urgency, such as a time-sensitive life decision.

These factors: confidentiality, type of problem and assessment of the severity of the problem were consistently mentioned as important in the decision to seek help (Stage 4), both in terms of whether or not to seek external resources and, if so, what type of resources to

look for. This stage is diagrammed sequentially before stage 3 (see flow chart, Appendix E), but with a reciprocal arrow between Stage 2: Definition and classification of problem and Stage 3: Help-seeking filter. This reciprocal arrow will become clearer in the following discussion of Stage 3.

Stage 3: Help-seeking filter. This stage combined the focused codes "Self-Perception," "Learned Messages" and "Working Model of Help-Seeking." It is similar to Mechanic's (1962) focus on individuals' perceptions of illness and the impact of these perceptions on outcome (whether the individual seeks and finds treatment). He defines "illness behavior" as, "the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon by different kinds of persons" (p. 189). He notes that symptoms are only as important as the individual's interpretation of them; some will "shrug off" the same symptoms that will send others to immediately seek medical care. It became apparent over the course of the interviews that similar emotional experience and cognitive assessment (stages one and two) would not necessarily lead to the same outcome. There was a "filter," an underlying schema, that became revealed through interview analysis that seemed to hold great weight in the decision making process.

Three main types of help-seekers were identified: Independent/Avoidant, Reaching/Anxious, and Supported/Secure. The three types of help-seeking patterns emerged from participants' descriptions of their help-seeking process. The connection to attachment theory came as the researchers spoke with each other about the patterns observed in the data. Some participants used the terms "avoid" and "anxious." I, the primary researcher, have worked in a clinic with a family systems emphasis that includes a lot of talk about attachment. The use of these terms initiated the question, "could attachment be part of the

process I am uncovering?" When I brought up this idea with my co-researcher, she confirmed that the involvement of attachment fit the data. I looked for disconfirming evidence and found that even interviews that did not explicitly talk about an attachment-related help-seeking filter, implied some kind of filter (e.g. Eden: "I just feel like I have to put up a front sometimes..."). This part of the theory was explained in the document given to both the internal and external auditors to check that the theory I proposed fit the data.

The terms "independent," "reaching" and "supported" were chosen in consideration of participants' reaction during a participant check. I and the secondary researcher felt that "avoidant," "anxious," and "secure," although they fit the data, and are clear and concise when writing for an audience of psychologists, might be offensive to those who recognized their quotes under "anxious" or "avoidant." There is a degree of pathology implied in the terms "anxious" and "avoidant," that is not with the terms, "independent," and "reaching." As many attachment theorists acknowledge, it is likely that attachment exists on a spectrum rather than distinct categories (Wallin, 2007). On the healthier end of the spectrum, several self-identified "independent" participants described this characteristic as ego-syntonic, sometimes even as a source of pride or life priority (Alan: "If you can deal with it on your own, then deal with it. If you don't feel you can, or if you know you can't, then you reach outside.") For this group being able to handle stress independently was a value.

Independent/Avoidant. This group of participants described a more internal, self-reliant help-seeking pattern. They emphasized the capacity to deal with one's own problems. On one side of the spectrum, participants saw this as a characteristic they were comfortable with and that did not necessarily stop them from seeking outside help if they felt they could not manage the situation on their own. On the other side of the spectrum, participants

described avoidance as a coping mechanism that left them feeling unsupported and alone in times of stress. Participants tended to describe this independence or avoidance as more characterological than situational or life-phase oriented. For example, Moshe began his interview by stating, "I think that you're definitely talking to the wrong person. My wife would be much better than me because I am just like a kind of a very closed person. I don't usually reach out for people for emotional stress kind of networking, et cetera." Moshe tended to describe this characteristic as ego dystonic; he was critical of himself throughout the interview for not reaching out more, identifying his wife as the one with the capacity to get support when needed, "You see how I kind of move very quickly away from emotional support and to kind of very...food and water. [laughs] Yeah, again, I'm a poor case study for this...it's poor that I could be anywhere. I could be in [America] or here...I've never looked for it [external support] so I don't know." His affect while he described this pattern indicated that he was uncomfortable with his tendency to avoid reaching out.

In contrast, Shoshana repeatedly described herself as "quiet," and "internal," "I'm more of an internal person. I don't really discuss my problems or my issues or things that are emotionally bothering me, with people so much." Shoshana, however, described a more complex relationship to this identity and a capacity to seek-help when needed,

> "I'm an internal person. I'll discuss things with people who are close to me, like my mother or my friend to an extent. I won't necessarily show 100% percent of what I am really feeling. I won't open it up all the way. If I think there's an issue professionally, I will speak to a professional. If not, the emotional difficulty I will discuss with someone like my mother or someone who's a close friend to me. But that's basically the process that I go through."

Shoshana expressed a preference to process her experience through writing before seeking help, both because it helped her clarify her own thoughts and feelings and helped her be more

"efficient," in knowing who to speak to and what to ask if she felt she needed to consult with someone. She prided herself on this point and noted it as advice she would give to someone else seeking help,

> "I think that a person really needs to define what they need help with. Some people are going through a situation and they're so disorganized in their head, what's going on. They don't even know how to translate anything. They're just so confused. I am a proponent of writing things down to clarify what is your issue. What are you trying to figure out, and what are your questions?"

Shoshana valued her independent nature and did not see it as prohibiting her from seeking help when she needed it. She did, however, note that at times not letting people see the full extent of her emotions limited how much they could understand about what she was going through and how much they were able to help.

Reaching/Anxious. This group of participants described their help-seeking process as one with a lot of trial and error, reaching out, having an experience, and reaching out again. Some participants described themselves as "anxious," describing an emotional uneasiness unless they felt that they had gathered a significant amount of information from multiple sources. Others described this help-seeking pattern as a developmental phase, before a supported or secure support system had been set up in their new community or life phase. Beth describes her help-seeking pattern as one that involved use of many resources and coping strategies:

> "The first time, I was dealing in the beginning a lot by myself, because I didn't know who to turn to. I turned first to an organization that I heard about called Tvunot, that deals with that kind of thing [adolescent high-risk behavior]. I tried to get guidance from them as I was dealing with a lot of pain and frustration with myself in not knowing who to turn to, basically. Then, when I heard about this organization, I turned to them. I also tried to speak to other people that had dealt with a similar problem and tried to get feedback and spent a lot of time and effort searching for the right shlichim [helpers] to help with it.
>
> At the same time, I had a lot of internal stress that I wasn't doing so well

> with, and then, the other little thing because there were also financial factors, and the pain. Then, we had to take care of help and getting direction, but I guess it didn't leave much for how to take care of my own internal stress. At a certain point, then...on the advice of a family member who knew of someone who was good with... EFT. I went for some of that myself because some of the difficulty and stress that I was having was tied in with my own issues. I had to deal with it anyway because I had to be a mother to everybody else. A wife and a mother, not just a basket case, I guess..." --Beth

Beth called me the night after I interviewed her with a list of other resources she had used but forgot to mention including help organizations, charity organizations, books, prayer, Rabbis and friends. In a memo, I noted, "Beth seems to be working from the underlying assumption that, 'more is better' or at least more thorough. I get the sense she needs to be able to tell herself she has done *everything* in her power..." Interviews with reaching/anxious participants tended to be longer, more detail-oriented and were often difficult to follow chronologically because so many resources were contacted seemingly simultaneously.

Some participants described themselves as reaching out a lot initially as part of their immigration process or acclimation to a new community or environment. Aaron described his early process in Yeshiva (a school for Torah [Old Testament] learning, in his case one geared for those who were not raised religious, but were becoming observant) saying, "In the beginning, I think that I got too much advice from too many places. That was a negative. And I found out that I need to make sure I'm just going to one or two places and that's it." Similarly, Talia described her Aliyah (immigration) process,

> "When I first made Aliyah, it was extremely stressful because I had one child that was very, very unhappy about being here...There was somebody who had an educational business for new olim [immigrants] and children that worked with the native Israelis that were born here, but he primarily targeted new olim. He helped me before I made Aliyah to register the kids for school, and so he was the person that helped me with academic issues for one of my children...I also turned to somebody who is was sort of an Aliyah buddy. I turned to Nefesh B'Nefesh, the organization that helped me to get here. I also

> turned to new friends...I think that, as a new olim, the best thing that you can do is turn to people that have made Aliyah before you did, because they share the same experiences. They can help you to get through the problems that you're going through, because they've already lived it. They can help you with solutions or make concessions, suggestions, or maybe direct you to the right resources."

For Talia and Aaron, reaching out to many people was described as part of a process toward familiarizing themselves with the new resources available in a new situation. The goal for them was to establish a long-term secure support network in their new environment.

Supported/Secure. These participants tended to describe the "ideal" help-seeking pattern they might advise for someone else as their own pattern. They described satisfaction with their support network, little resistance to seeking-help and a feeling of relative calm, or at least significantly decreased stress, after reaching out to their support network. This group did not necessarily describe more "successful" outcomes in terms of situational outcome, but rather reported a more "stream-lined" help-seeking process resulting in a general feeling of support throughout the time of stress.

> "I had a support system [before this incident]. I had my people lined up who I use on a regular basis, who I talk to. Maybe I use them, I don't know. I have an amazing support system. I speak to these people on a daily, weekly basis. When I have a problem, I just call them automatically. I don't even think of who do I need to call. I have my people...I think it's important to have the support system before the problem happens. I think that's what I learned the most in OA, is having that support system lined up in a benign way that when something happens I should have that support. Also, just learning who to trust for what. That's important for me, too. I'm very happy I have this cousin of mine because she's amazing. I could tell her anything. Anything." --Gitty

> "When I am stressed out, I speak to my husband, I'll speak to my mother, I'll speak to my sister. One of my sisters is 16 months older than me. We understand each other very well....My mother also understands me very well, but at the end of the day after hearing from all of them, whatever they calm me down about, or anything, I really only get calmed down if at the end of the day, I come to the realization myself, or I talk to myself. That's my biggest way of getting out of whatever situation I am in. I could hear what other people say,

> and I could listen to them, but until I'm like, "OK, do you know? Talk to yourself. This is all you need to know and you'll be fine," then I really get past the situation."-- Bracha

These participants tended to describe a comfortable and flexible pattern of behavior, a satisfaction with their support system and an overall effectiveness of their pattern on decreasing stress.

Perception of the acceptability of help-seeking. Both researchers noted a wide variety of reporting about the acceptability of asking for help ranging from the assertion that it is the norm in the community to ask for support to the perception that it is unacceptable and the expectation is to keep things as private as possible. Although there are many sub-communities within the Orthodox Jewish community in Jerusalem and the differential reporting may be due to differences within the sub-communities, part of the discrepancy may be accounted for by this "help-seeking filter." Interestingly, several participants with a more independent/avoidant filter or schema, reported that help-seeking was acceptable and expected, although not something they engaged in regularly. For example Moshe, quoted in the independant/avoidant section above, described his community as follows,

> "I think there's a support net that's there of people who want help, and it's spread. As I said before, it's out beyond Jerusalem and out of Jerusalem. I was pretty impressed. I hadn't even thought about it until now you just asked the question. I always kind of assumed it's there, but when it comes together, and you see it come together, it's pretty impressive...I could even name people in the community that you could just reach out to, and say listen, "Listen, we're having a tough time financially, whatever. Could you do something in a way that's under the radar?" I think there are a lot of people like that here."

Chani, who described dissatisfaction with her support network in Jerusalem and a tendency, although not absolute, toward independence, said,

> In the frum [religious] world I feel like in general, it's more expected that there are going to be things that are too big for you to handle and you are supposed

> to ask for help. You are supposed whoever, you're supposed to ask...The whole concept of bringing a shiloh [question asked to a Rav] with somebody doesn't exist [in the secular world], it's like a new world. It's not like a weakness that you're asking for help. It's a normal thing. I think at the beginning of this situation, I wasn't expecting to ask for help, but at a certain point, it didn't feel like a barrier, it just felt like a reframe, it was like. "This is one of those times that you call a Rebbetzin and try and see what to do."

This apparent discrepancy between help-seeking style and perception of the acceptability of help-seeking may be accounted for by the characterological explanation that independent/avoidant seekers tend to express; they may perceive themselves as those who do not readily seek help, but perceive the help as more acceptable to others than to themselves.

There was also an overall agreement that seeking help is more acceptable today than it has been in the past (Nancy Goldstein: "It's much more open. People know about names of therapists." Gitty: "The whole idea for help is a new thing, I think, in our community, going for help." Michal: "I believe today also, but there is in the religious community more narrow mindedness than in the open world, for sure, in these issues...It's more like a stigma, I would call it. But I think today I wouldn't put it into the same [category as 20 years ago]. Then, for sure, you were stigmatized if you can't deal with your problems.") Further research is needed to understand the interaction between community acceptability of help-seeking, help-seeking type or filter, and perceived acceptability of help-seeking.

As mentioned in the section on Stage 2, stages two and three were not described by all participants as sequential. Some participants described no cognitive processing of the problem but rather an automatic response. In these cases it seemed like the help-seeking filter, the schema the individual uses to navigate situations of high stress where a help-seeking decision is required, either overrode the cognitive process or was experienced as the more salient factor in that help-seeking decision. The cognitive process may influence what

part of the help-seeking schema is utilized (stage two, then stage three), and, in some cases the filter may influence the cognitive process (stage three impacting stage two).

Stage 4: Help-seeking decision. Stages 1-3 culminate in a decision to (a) seek external resources, (b) independently manage the stress or (c) engage in a parallel process of seeking external resources while independently managing part or all of the stress (a and b). Previous help-seeking theories, because they were formulated primarily around physical health and are behaviorally focused, do not tend to address intrapsychic coping strategies. Anderson (1995) includes, "personal health practices" with the sub-categories of "diet, exercise and self-care," but because it is a behavioral model, he does not include non-behavioral coping such as self-talk, prayer, introspection or minimization and denial. Several participants were clear that they were involved in parallel help-seeking processes: one that accessed outside resources and one that was more independent (Racheli: "I met with a mentor, Bryndi. I spoke to her a lot about my concern, and I cried a lot and I prayed a lot." Susan: "Then I spoke to different people, and what else did I do? I cried. I prayed. I spoke to some great Rabbis who were very good and savvy at kids at risk and difficult kids." Chanuch: "I guess those cigarette breaks were helpful for me to go to Yeshiva, and just talk to some guys; get a cigarette with someone, and talk to them. I think I also did a lot of just thinking about myself personally: 'What does it say about me? What do I fit, what do I not fit?'")

This decision to seek help, independently manage the problem (which includes choosing not to seek help) or both is guided by stages one through three: the emotional reaction to the stress, cognitive categorization of the problem and the individual's help-seeking filter to determine the help-seeking process he or she will engage in.

Stage 5A: Seek external resources. When participants chose to seek external resources, they noted seeking helpers with similar religious values, a degree of expertise or wisdom, motivation (i.e. a preference for those who were not financially motivated), recommendation by someone trusted, community respect and the importance of a personal relationship, someone who "knows me well." Many participants used the language of someone who can be "trusted;" when asked what characteristics made someone trustworthy, participants listed the characteristics above and, again, the issue of confidentiality. Many participants mentioned concern that their struggle should be kept quiet and chose resources that ensured a degree of confidentiality.

Family first. Participants expressed an overall preference to go to family first where appropriate. This was the most frequently expressed childhood message people described: the message to seek help from parents first. Although family of origin size was not asked about in the demographic questionnaire many of the FFB (Frum/Religious from birth)-identified participants noted a larger family size and siblings or cousins very close in age who are significant figures in their support systems. This strong family preference was noted by both researchers.

The Rabbi as a resource. Understanding the role of Rebbeim (plural for Rabbis) in this population is essential when considering implications for community outreach and psychoeducation. Rebbeim were discussed as a frequently used resource and point of access to care, especially in help-seeking processes categorized as life-decisions. Here the data speaks best for itself; it is important to understand how the participants themselves describe these relationships. The following are examples of people's description of the role of a Rabbi as a resource:

> I'd say, the Rav is always first, our posek [Rabbi of Jewish law] especially the one who helps us make decisions, who knows the family situation, who knows where we're coming from, who knows where we're going, who has helped us until here, who knows our emotional background, and what could be an issue for us. We for sure go there first, and he's always the most helpful. ... But sometimes he could be saying something, and maybe because I'm young and not ready to hear that, I need it to be cut down for me and explained. I need tools to deal with that. I can't just take it fully and go with it or even when I do take it, I need just more hand holding to do what he said. So that's when he actually sent us more. He knows himself, he's not licensed and he doesn't have the time to give us tools and tell us each step of the way, how to deal with each situation. He's giving us the big picture, like, 'you're doing the right thing or I think you should be doing this. This is what's good for you and you're going to be happier this way. It's better for your life for your everything.' You really get the clarity which direction to go. Then he'll send you on. --Rivka Gittle

Rivka Gittle described a long-term relationship with a Rabbi that she and her husband went to for guidance. This same Rabbi was a point of access to mental health resources when she and her spouse needed it. Most participants who mentioned going to a Rav spoke about an ongoing relationship and his role as both an advisor and a source of information about community resources. Many participants also spoke about their Rabbeim as an emotional support.

> For me personally, I think that number one, throughout the whole frum Jewish education system, people are encouraged, especially when you get older as a teenager and on, to have a Rabbi figure, that you cannot just ask favors to, but someone as a mentor, somebody to get close to, to be able to speak out issues, that's obviously encouraged.
>
> My Maggid Shiur [the lecturer at his place of study] was the person that I chose at some point in time to be that person. It wasn't a one off time that I decided to speak to him. I speak to him at lot, and at that point in time he was there for me so I would speak to him . --Alex

> The second Rav I'm very close to I also go to him for advice. He was able to help me more with the Israeli system like there's a certain Rav that people call in the medical community so he told me to get in touch with him. Another Rabbi helped me translate that conversation because he didn't speak English. That helped out a lot. There's a guy in the community that put people up in the

> hospital who were there for many days. He got me set up with that. He helped me find all the organizations...It was helpful that he did a lot of the ground work for me. He knew the stuff existed. That was very helpful.--Aaron
>
> I have a close relationship with my Rabbeim. If I need to cry, I cry to them. --Noson

Participants also spoke about various types of Rabbis, some more accessible, a more consistent figure in their lives, others less accessible but well known and respected. Nosson described at length why he chose to go to a very well known Rabbi who did not know him well over his Rav, who he had a close connection to.

> I think I should explain the idea of going to Rav Chaim Koniefsky [a very famous Rav]. See? I have a theory, which I think a large part of Charedi population shares, which is very difficult for a secular person to understand. In other words, I don't believe that Rav Chaim Koniefsky is a prophet, nor does he believe that he's a prophet. How does it make sense for me to go to him for a one minute interview, and that he should decide something crucial in my life? How does he presume to do that as an intelligent person who knows nothing about me or my situation? Why do I think that this makes sense?
>
> I have a theory... that when you're under stress and you really don't know what to do, then you're able to turn to the Ribbono Shel Olam [G-d], and he will answer you. Because we have no prophet, there's nobody, specifically, to go to for prophecy. So what Klal Yisroel, the Jewish people, have developed a theory, that if you really need to ask G-d and you're sincere, then He has to answer. You go to the holiest person that you know, and if he has an answer in his head, knowing that he knows very little about you, and he feels like saying something. He believes, and I believe, that came from Hashem. I have some anecdotal evidence to this, but not really...I don't have any proof. --Noson

Yosef described the "totem pole" of Rabbeim and another facet of a Rabbi's role; he spoke about learning how to think, how to make good decisions, by learning from his Rabbi.

> ...Here, I needed somebody that I felt had the same value system that I have but could still understand the value system on a higher level. That could help me make that decision. Either help me with the decision or tell what the right decision was.
>
> It's very interesting, both of them, both Rabbi Aaron Leib and.., they didn't really make a decision outright which is a very shrewd thing... Really, he didn't make a decision. He talked it out with you and based off of that, he was sort of like, "OK, you got to your answer and it's OK. The decision that you

> are making in our value system is a good decision."
> They all sort of did that.
> Ilyssa: Did that feel helpful for you?
> Yosef: 100 percent helpful. It was helpful for a few different reasons: It's helpful to know that you have someone to go to help you make a decision. But it was also helpful to see the process that they would ask, what type of questions they were asking and how they were directing the conversation could also be helpful in helping other people make decisions. It was a learning process, not just getting the answer but it's an experience, a life experience to try to see...
> Ilyssa: Like you were learning how they thought through the question. It sounds like in deciding to do what you did, finding someone of the right value system you talked a lot about value system. How did you know who to go to? How did you find the right person with the right value system for the situation you were in?
> Yosef: It was people that are probably...somehow either me or a close colleague or a friend has also come in contact with and said, 'Oh, this is a good person to speak with'...The reason why I went to Rav Aaron Leib Shteinman, even though he's not English-speaking is because I felt that for that question I needed somebody that was at the top of the totem pole...
> Ilyssa: How do you know who's on top of the totem pole?
> Yosef: Oh, that's a good question... I'll tell you most probably is that the people that you see that are on the totem pole, where they go, meaning Rav Nosson Tzvi, if he had a question would go to Rav Eliyushiv (very well know, respected, Toral learned, Rabbi) or Rav Aaron Leib Shteinman.
> People that I knew from America or from here that wanted an English speaker would go to Rav Hirsch. So I see where people who are higher on the totem pole than I am are going. That's really it more or less. --Yosef

Some Rabbis are more accessible than others. The ones "on the top of the totem pole," as Yosef describes, are difficult, although not impossible, to access. Participants described long waits and/or having to speak to many go-betweens before gaining access to the Rav they wished to speak to. For example, Racheli described, "I had to go to through all these different avenues. I had to tell people that I didn't want to tell to get them to understand how important it is that I get to speak to him. I didn't want them to know. But they were standing in the way and there was no way for me to get around it without telling them. That was hard." Although not always immediately accessible, participants described a general knowledge about how to

access Rabbeim on every level of "the totem pole." Most participants mentioned closeness to one or more Rabbis who they felt knew them (and often their spouse) well and was regularly consulted before making major life-decisions. Participants also discussed the Rabbis they had a close connection to as a source of both emotional help and often as a point of access to other resources in the community.

Religious coping. The literature on help seeking discusses two religious coping styles theoretically proposed as important in determining help-seeking across various religious groups: deferred coping, which involves the expectation that G-d will intervene and solve problems (Pargament et al., 1988) and deistic coping, which assumes that G-d has given individuals the ability to solve their own problems (Phillips, Pargament, Lynn & Crossley, 2004). This population does not appear to fit entirely into either paradigm; participants expressed both an assumption that G-d has given individuals the capacity to solve their own problems and also a belief in divine intervention. David described both simultaneous beliefs in his interview,

> "OK. In terms of actions that I did, in having to deal with them [neighbors in a property dispute]. Everything was just asking Da'as Torah [Rabbis who are very well learned], I had to ask the dayanim [judges] on the beis din, I asked my Rosh Yeshiva [head of where he studies], I asked a posek [expert in Jewish law], I was just trying to m'chazek [strengthen] in emunah [belief that G-d runs the world], and if it's going to happen to me, it's min ha'shamayim [from G-d] to have tzaros [difficulties], or whatever. Things min ha'shamayim could have been cholei [sickness], could have been other things. I'm not saying it succeeded 100 [percent], but that was my main approach. That people can't cause you more harm than is decreed from shamayim [from heaven, or from G-d]. "

In his interview, David mentioned trying to talk to the neighbors, going to legal resources, and eventually moving. He described a great degree of personal responsibility in dealing with the situation and protecting his family from neighbors who began making threats as a result

of a property dispute. Simultaneously, he described trying to do so with the outlook that "people can't cause you more harm than is decreed from shamayim." Overall, participants described a greater emphasis on personal responsibility than an assumption that G-d would intervene in a way that did not require some degree of personal responsibility or action.

Religious match. Analysis of the interviews revealed a heavy emphasis on seeking help from those with similar religious values in problems categorized as emotional, interpersonal and/or life-decisions. Participants did not express a preference for medical resources to be a value match. Those who mentioned mental-health resources tended to state a strong preference that the psychologist, therapist or social worker have similar religious values.

Mentor. A trend for younger women to have a formal mentor emerged through the course of interviews:

> OK. I read a lot. I'm out there. I like knowing what's going on, from articles about the importance of having a mentor. But by the time I was reading those, I knew. I think it started when I was a teenager. You have a bunch of questions, and I tried different ways of figuring it out myself. But you realize you just need to have a connection with somebody to talk to. And you hear about it. Even girls talk about that one teacher that they were able to talk to. Maybe we didn't use the word 'mentor,' but you needed to have one, I forgot the name, but you needed one main teacher that you could to talk to. -- Rivka Gittle

> I do today, try to encourage my children, my married children, it's not a busha (embarrassment)...to get help. It's accepted and it's much more acceptable today. Even in the schools the girls have this--what do you call it?...The yoetzet chinuchit (educational counselor for children), and they're busy. Today it's a whole shtick that the girls have a teacher that they hang around. You can't compare the generations, that's how I see it. -- Michal

> She's my mentor from Neve [the seminary where Racheli studied]. Yes, I think because I look up to her a lot. I love her. I think she's incredible. I would love to turn out just like her someday. She's really incredible... --Racheli

For many younger women in the study, women under forty, mentors were mentioned as first

or second resources. Mentors tended to be described as less formal guidance figures that Rabbis or Rebbetzins (female rabbis). A Rebbetzin with whom the participant had frequent contact might be referred to as a mentor as well. The relationship described was one of closeness, frequent contact, accessibility, emotional support and guidance.

Gender differences: When seeking external resources, both male and female participants spoke about the importance of similar religious values, expertise/wisdom, motivation (generally more trust for those who are not motivated by financial gain), recommendation, and community respect and personal connection. Women tended to emphasize personal connection slightly more than men and men expertise and community respect slightly more than women.

There was also a difference between men in full-time learning (engaged in Torah study eight or more hours a day) and/or involved in Jewish education (teaching in a Torah-based educational program) versus men employed outside of learning institutions. Those involved in full-time learning, as might be expected, quoted more religious coping (reframing the situation according to Torah values, going more quickly to Rebbeim, prayer and/or engaging in Torah-learning as a way to deal with stress). Men who were professionals (a lawyer, a man working in bio-tech, a therapist and a dental assistant) tended to discuss more independent or information-oriented approaches to problem solving before consulting a Rabbi or using religious coping strategies. This may be a function of proximity; men involved in full time Torah study are often in a building with several available Rabbis who are there to provide support and guidance for most of their day.

Stage 5B: Independent management of stress.

The independent stress management tools mentioned included: writing, self-talk (e.g.

Bracha, "I say to myself...'you'll be fine...'"), prayer, crying and denial or minimization of the problem (Nathan: "I think about and go over, and try to minimize the problem. Usually after a while, I have good nature, I sort of forget about the problem or it gets less and less.") The choice not to seek further resources internal or external (either as a function of denial or a realistic assessment that the problem does not require, or no longer requires a help-seeking process) was also part of this stage. Several participants also mentioned reading; some included this as one of the many resources they reached out to, some described this as part of an independent help-seeking process, while others listed without qualifying it either way.

Stage 6A: Barriers and facilitators to external resources.

Access to resources. Lack of availability, transportation, money, a language barrier, and lack of time were the most often mentioned barriers for this population (Rebecca: "I was on a waiting list for a year for a chinuch [parenting] teacher, Spetner, I don't know if you've heard of the name. She's amazing, she's incredible. I finally got an answer after a year of waiting, last December." Bob: " It was a bit of schlep because we didn't have a car...that was difficult." Racheli: "Getting that letter from Rav Shterenbuch was a process. I needed him to be more accessible. But there is no reason he should have been more accessible to me." Naftali: "Money was an issue. It's [therapy is] very expensive,..." and Chani: "I just felt like I didn't necessarily know the right people.")

Internal barriers: *Thoughts and emotions that acted as barriers*: Many participants (not only independent/avoidant help seekers) described thoughts or feelings that they identified as barriers to accessing resources (Eden, "Once I had calmed myself down, I didn't want to go get the emotional and physical support that a hug would have gotten from a neighbor because we all put up a front." Michal: "I remember feeling very embarrassed to

come [to see a therapist], like if the world was coming to the end, to go to seek help. It is a certain, maybe, embarrassment in seeking help." Shoshana : "For sure my internalizing everything affected maybe the way that I got help." Chanuch: "I probably felt like I had to keep the strong presence in the house, not seem to be very vulnerable, which might not have been so helpful for my wife in terms of us dealing with it together. The old...what do you call it? The persona, or whatever that you have to be the strong stoic type.") Some participants mentioned a previous experience with a resource that left them with a negative association to a particular type of help. Two participants mentioned unsuccessful therapy processes that left them with unpleasant feelings and thoughts about the likelihood of mental health resources being effective; one participant described a mentor telling her she was too much for her (the mentor) to handle, leaving the help-seeker feeling discouraged about continuing her search for a mentor. These experiences left participants with assumptions about what would or would not work for their next help-seeking process.

Stigma. When asked explicitly about barriers, only one participant mentioned stigma as a barrier to her own process (Beth: "I felt I was afraid of the stigma, but not anymore. Not for years now. Stigma because like the community-- what if someone knows I get counseling, that kind of thing.") Several participants mentioned stigma when asked about messages they got about where to go for help in childhood or mentioned it as a general perception of their community. This may indicate, similar to the finding of Vogel et al (2007) that self-stigma or internalized stigma is not the same as public stigma and is a mediator between public stigma and help-seeking (i.e., a perception of public stigma does not necessarily mean that this stigma has been internalized in a way that affects help-seeking behavior).

Perception of resource as trustworthy. Another barrier to care was the perception

(true or false) that a resource did not have the capacity to be helpful (Noson: "I'm a Charedi [Ultra-Orthodox] person, and it's very uncomfortable for me to use any secular means of support. I've found through my experience, that secular people can't really understand my mindset." Rivka Gittle: "I originally started off with someone, but very quickly, with my, I guess, normal but more complex issues, she was, like, 'I'm not equipped for this. I just don't have answers for you.'") Perception of a resource as untrustworthy prevented participants from seeking that resource.

Facilitators: Participants described knowledgeable well-connected individuals, charity organizations and people who had been through similar experiences (because they knew the relevant resources, had personal experience with these resources and could make first-hand recommendations) as facilitators in their help seeking processes. Some participants noted a personal experience they had previously with a resource as a facilitating factor in their process. Three interviews mentioned a particular Rabbi in the community who has compiled a database of the best doctors for various illnesses in the Jerusalem area as a particularly good facilitator; one of these interviewees noted that this resource is only for medical, not mental-health, resources.

In some interviews, participants mentioned the involvement of their spouse in their help-seeking process without identifying the spouse as someone they had reached out to. On three separate occasions I noticed that interviewees (all male) used "we" when describing their help-seeking process and I had to clarify if the "we" referred to a spouse. Analysis of these interviews revealed that this linguistic marker indicated a facilitator outside of the help-seeking process. Regardless of the individual's emotional response, classification of the problem, help-seeking filter or decision, the spouse knew, because of the nature of the

problem (in two cases a medical issue with a child, in the other, an apartment renovation stress) the spouse knew about the problem and was accessing resources on behalf of the couple or family. In these cases, the spouse's involvement was not a matter of choice but facilitated access to resources.

Stage 6B: Barriers and facilitators to independent management of stress.

Access to coping strategy resources. Some participants noted a desire to manage the stress on their own, but some barrier that did not allow them to do so, or did not allow them to do so in a preferred way (Bracha: "I think that's a really chronic lack of sleep [that stops me from being able to cope sometimes]." Moshe Leibovitz: "I run or workout or whatever. It's interesting because I hurt my knee so for the past two months I haven't been able to run or bike as much as I used to. I do it more for my head than I do for my body, but it's helpful to get out and run and get things out. It's helpful.") When there was not access to a preferred coping strategy, the individual was left looking for a new way to manage the stress; sometimes this was a motivator to seek an outside research, more often, the participant found a new independent coping strategy.

Ego syntonic vs. dystonic assessment of choice. Participants who described their coping strategies as healthy and in-line with their self-image facilitated their own use of these strategies. Alan spoke about the utility of writing things down for himself, "Also what I found helpful relieving stress, not the specific situation, is quantifying the stress. Meaning, people feel a lot of stress from different things, but if you can write on a piece of paper saying, this is what I am stressed about or this is what I need to accomplish because usually these things that you have to accomplish cause you stress." He identified this as a praiseworthy coping strategy and described it as a frequent way he deals with stress; he said that he writes things down each Friday before Shabbos (the Sabbath) and did so consistently

during the stress he described in his interview.

In contrast, Chanuch described his relationship to cigarettes during a child's encounter with diabetes as ego dystonic. He described the connection he felt to people he smoked with as helpful during that time, but always rolled his eyes or smirked when he spoke this coping mechanism, indicating that he was not proud of this choice. He mentioned in his interview that he had quit before the incident, indicating that it was ego dystonic before the time of stress. This assessment of smoking not fitting his desired self-image meant that he was battling a desire to cope in this familiar way. Similarly Moshe discussed his coping strategy of not talking to others ("It's more stress for me if I talk about it than if I don't...") in a tone of disapproval. This appraisal may be considered a barrier to the use of this coping mechanism.

Stage 7A: Help experience. This stage refers to the behavioral outcome of the decision to seek external help, the actual act of going to family, a religious figure, a mentor, a friend, or professional (only one participant mentioned using the internet as part of her help experience). Participants described help experiences with doctors, mental-health professionals, friends, family, neighbors, government offices and agencies, Rabbis and other community resources. Because the focus of this study was the process people in this community use to seek help, I did not ask about and participants tended not to share details of the help experience itself. The evaluation of the help experience is described in Stage 8.

Stage 7B: Self-help experience. Participants mentioned writing, prayer, "self-talk," denial, and minimization as "self-help" experiences or ways of independently managing stress. As mentioned in Stage 4, many participants engaged in a self-help experience in conjunction with accessing outside resources. Participants' evaluation of the effectiveness of self-help varied widely (see Stage 8).

Stage 8: Evaluation. During and after the help or self-help experience participants described an evaluation of the help. They evaluated the resource as helpful or unhelpful and as one that they will or will not use again. An evaluation of unhelpful for a particular situation did not necessarily mean that the resource would not be accessed again. For example, Rebecca described going to a child psychologist who she found very knowledgeable and would use again, but gave unhelpful advice for the particular situation she described, "Basically, it was very frustrating. Because it was very good advice she gave us, she taught us a very good lesson for life, just to ignore certain things... But I just didn't feel it was working for [my daughter]. She was going nowhere with it." Later in the interview, Rebecca explained, "Like I said, it wasn't a help in the end, because it totally didn't work for her. But I would not tell you that I regretted going to her and paying her the amount that I had to pay her. She definitely taught me something very good for life that I'm sure could be used for any other situation with any other kid." This evaluation likely acts to inform future help-seeking decisions, particularly at the level of the help-seeking filter (Stage 3) and at the level of barriers and facilitators (Stage 6); the experience either confirmed or disconfirmed the participant's filter and the experience either facilitated or impeded accessing that resource, or similar resources, in the future.

Helpful/not helpful. Participants discussed practicality of advice, empathy, validation, personal connection, decision-making help, help staying in the moment in times of crisis and religious guidance (reframing a situation in accordance with Torah-based wisdom) as helpful. For example,

> "So on one hand, the actual going [to a Rav] could be very stressful, but like Chazal (Jewish sages) say, 'ain simcha katares ha'svekos (the greatest happiness is the relief of doubt).' When you walk out, even though you may

> have another stress, OK, what do I do now? But at least you have a clear answer to that question."--Yosef
>
> "I guess, once things start kicking in, just getting a lot of the technical information [about diabetes] out about what the plan was here, medically; what the plan was, there, just getting him information was helpful because it was a great, big unknown. That was helpful."--Chanuch
>
> "I liked it very much. Specifically, with the issues I wanted to deal with, I spoke with the therapist and the Rabbi who connected me with him, regularly. I saw results almost immediately. I was given assignments to do and I did them. When I did them I saw results from them. That was very satisfying." --Naftali
>
> "What was helpful, she was able to talk me down and tell me to keep breathing and that I was OK, that we'd deal with it." --Eden

Unhelpful experiences tended to be the opposite of those defined as helpful: impractical advice, lack of empathy or validation, and lack of personal connection. For example,

> "There was a social worker, I think that the hospital had, that we had to have in order to...I think my wife had a bit of a connection with her. I think it was more technical things. I don't think she was all that emotionally helpful."--Bob
>
> "One time, for example, I cried to somebody and she told me, "You know, you really shouldn't be talking about such personal issues." I really had to ignore it, because if you're quiet about your issues, how are you supposed to get them solved? That wasn't really the type of answer that I wanted."--Talia
>
> "The downside of that [my husband's "level-headedness"] is that sometimes it's not practical things that we need, it's much more the emotional, just sitting with it, and understanding what it is that we're going through, as opposed to going through it together and practically dealing. That's what was missing for me in that."--Nancy

Would/would not use again. The evaluation to use or not use a resource again was influenced by the assessment of the helpfulness of the resource in the situation noted, and also the ability of the resource to be helpful in the future. Gitty described a relationship with a cousin who had proved helpful many times in various situations and was particularly helpful in the situation she described. "That was very, very helpful to get me out of the crazy

and into the 'We'll have a plan. You will. You're not stuck in this moment forever.' She's very good at that. We do it for each other. We're very good at doing this for each other, just reminding each other that everything passes." She implies that she will continue using her cousin as a primary resource when she is under stress.

In contrast, Chani described a course of therapy she evaluated as unsuccessful, "The counseling was also with my husband and we both just felt like it was...We had a particular issue at a particular time and it was going so slowly that we felt like if we went there once a week, it would take us probably three years to resolve whatever was happening and we were both sensitive enough people that we figured out we could probably work it out on our own faster with that he was doing." She later stated that advice she received from a Rebbetzin was more useful and stated a desire to have access to more Rebbetzin figures in her life. Evaluation of the resource appeared to shape future help-seeking patterns.

Stage 9: Re-definition of problem (or remaining problem). After seeking help and evaluating its effectiveness, participants often described a new experience of the problem at hand. For example, several participants noted a decrease in stress after consulting a Rabbi because they felt they had some clarity on what the right decision was for the situation. In some cases the decision itself was the stress, in others, the decision was the beginning of another stressful process (e.g. beginning a move, declining a job offer or telling someone a personal piece of information that was uncomfortable). For example, Shoshana described a sequence where her mother told her she could not help her through the situation she was in anymore,

> But when it got to that point where she didn't think she could help me and she felt like it wasn't good, that was where she stepped back and said, "There's nothing else that I can do. If you're going to decide, you're going to go ahead

> with it, then I can't really stop you." [chuckles] She told me this guy got the message clear that she doesn't think I should marry this guy. On the one hand, she was very helpful and was great, but on the other hand, when she stopped like that, I was like, "OK. What am I supposed to do now?" I was scared.

Feedback: In the case of Shoshana above, "I was scared," is a new emotional response to the stress of her mother not being able to help her further. This new problem began the process for her again; she felt stress (stage 1), defined the stress as confidential, life-decision oriented and emotional and severe (stage 2), this assessment and her self-identified "internalness," or, for the purposes of this study, idependant/avoidant filter (stage 3) led her to journal and speak to a close friend in a similar situation (stages 4 and 5); the process continued from there.

This feedback is represented in the flow chart (Appendix E) by the arrow connecting stages nine and one. The feedback loop continues until the stress is reduced and the person assesses the situation as no longer needing help, or the person chooses a coping strategy of denial (perhaps a temporary fix).

Chapter 5: Discussion

Summary

This study focused on the question: What is the process that Orthodox Jewish English-speaking immigrants in the Jerusalem community use to seek help in times of emotional stress? A qualitative, constructivist grounded theory approach was used in the collection and analysis of 26 interviews. Standards of trustworthiness as outlined by Morrow (2005) were used to ensure the rigor of the study, including the use of a reflective journal, memos, a co-researcher, internal and external auditor and the use of a participant check. The result was an attachment theory-informed, nine-stage cyclical model of help-seeking as well as in-depth descriptive information about individuals' unique and culturally specific experience of the nine stages. These findings have important implications for theory, research, practice and education.

Implications for Theory

Strauss & Corbin (1998) described a theory as "a set of well-developed categories" that are then "systematically interrelated through statements of relationship" into a "framework that explains some relevant social, psychological…or other phenomenon" (p. 22). The model that emerged from this study fits this definition: the data was categorized into stages with sub-categories and the stages are interrelated with the relationship clearly explained. The framework explains a phenomenon that is relevant and informative for theory, research and practice with the population studied. Thus, I will refer to the model described in the results section as a theory. Because the result of a grounded theory study is theory, some discussion of how the model compares to existing literature is included in the results section. This section is, therefore, focused primarily on the implications of the findings of this study.

Help-seeking theory. The theory that emerged from this study represents, to some degree, an integration of the Andersen and Mechanic models. The findings of this study confirm that for English-speaking Orthodox Jewish immigrants in Jerusalem, Andersen's chronological behavioral model: Primary Determinants to Health Behavior, then Health Behavior and finally, Health Outcomes fits the experience individuals describe. The main criticism of Andersen's model is that it does not give enough weight to cultural specificity (Guendelman, 1991; Portes, Kyle & Eaton, 1992). Where Andersen's model provides a basis for conceptualizing help-seeking behavior across groups, the model proposed by this study paints a detailed picture of the help-seeking behavior of a particular population.

An important part of the theory that emerged is the attachment-informed help-seeking filter described in stage three; there are some similarities between this formulation and Mechanic's concept of illness behavior or the assumption of the "sick role." Mechanic defines illness behavior as primarily influenced by the individual's level of adoption of "the sick role." He explains that adoption of the "sick role" is influenced by the norms, values, fears and expected rewards and punishments of seeking help (1962). This study found that help-seeking was greatly influenced by individuals' underlying schemas, or filters, influenced by learned messages, values, perception of community norms and past experience, similar to Mechanic's idea of the "sick role."

Where Andersen focuses on behavioral chronology and Mechanic on sociologic influence, the theory this study suggests takes a psychological approach that combines the two. Participants described the behavioral processes and outcomes of seeking help and also the intra-psychic process that allowed or impeded decision making. This is an important contribution to help-seeking theory; the qualitative nature of this study allowed participants

to describe not only what decisions they made, but how they made them. The contribution is the added layer of complexity that underlying Andersen's model is a filter individuals apply to the process and informing Mechanic's concept of the "sick role" is a sequential process that moves the internalized norms, values, fears, etc. into the behavioral realm.

Population specific theory. This study proposes an attachment-informed nine stage cyclical feedback model of help seeking. This theory, although it may be applicable to other populations, was developed only to describe the help-seeking process for English-speaking Orthodox Jewish immigrants to Israel. The theory, presented at length in the results section, is the only research available to date on this process for this population. It's implications for theory include: a beginning to understanding the unique patterns and needs of this population (rather than studying this population only in comparison to the general Israeli population, the only existing literature at present). It also supports the incorporation of attachment theory into theories of help seeking, indicating that future research aiming to create theory about help-seeking in specific populations should address and incorporate attachment theory. Some further implications for theory about this population are addressed in "Implications for Research."

Implications for Research

This study is also a contribution to the literature on how access to care is influenced by minority status, religion, gender, psychosocial barriers, structural barriers, attachment, immigrant status and therapist match. This research adds a qualitative perspective on a unique population with a complex intersection of identities to this body of literature. It is also a contribution to research and theory about the Orthodox population in Israel.

Minority Status. None of the study participants mentioned minority status as a major

influence in their help-seeking process. One participant mentioned his status as a religious Jew complicating school choices for his daughter with hearing-loss, but even this discussion was tangential to the help-seeking process he was describing. The seeming non-importance of minority status may be due to general lack of help-seeking outside of the Orthodox community; it may be that participants were not describing situations where there minority status was salient.

Access to care literature is focused mostly on minority groups seeking help in majority contexts (Becker et al., 2010). This study, though focused on a minority group in Israel, did not presuppose that individuals were trying to utilize the resources offered by the majority culture. What emerged was a complex picture of resources and points of access to those resources that were relatively insular. Many participants mentioned accessing medical resources outside of the Orthodox community (often through a trusted reference within the community), but management of emotional stress was primarily done through family, friends and religious figures.

Religion. As described briefly in the results section, this population did not appear to fall into one of the major types of religious coping defined by Pargament et al. (1988): deferred coping, which involves the expectation that G-d will intervene and solve problems and deistic coping, which assumes that G-d has given individuals the ability to solve their own problems (see Results section, stage 5a, religious coping). Pargament notes that individuals' degree of adherence to one of the aforementioned religious coping strategies is likely correlated with degree of adherence to religion and religious fundamentalism. The group studied likely falls under the definition of a "fundamentalist" group and by definition, Orthodox Jews identify as adhering strictly to religious law. The findings from this study

contradict Pargament's notion that degree of adherence or fundamentalism is predictive of greater adherence to either deferred or deistic coping. This population, rather, demonstrated a strong belief in personal responsibility as well as reliance on prayer and the religious outlook that everything is ultimately controlled by G-d.

Particularly important for this group was the role of a Rav, a Rabbi consulted in times of emotional stress and/or life decisions. For this population, consulting a Rav was a normalized, respectable, even expected part of the help-seeking process. For men, a Rav was often cited as the primary point of access to mental-health resources.

Some participants mentioned prayer as a self-management resource, but none mentioned this as a the sole resource in their help-seeking process. Prayer has been noted as an effective coping strategy for stress (Wamser et al., 2011) and a survey study by Lowenthal & Cinnirella (1999) found that among Christians, Jews and Muslims, prayer was perceived as a more effective intervention for depression than medication and psychotherapy. This research neither confirms nor denies these findings. For this population prayer was seen as a resource but did not appear to be utilized more or less than other resources. The interview protocol asked the participant to recall a time when he or she was under significant emotional stress. It may be that prayer alone was utilized more for stressful situations perceived as less severe. Another possibility, noted by the secondary researcher, is that prayer may be so fundamental that, when speaking to an in-group interviewer, it was assumed that the interviewer would know this was an integral part of the process. Future research on this population may want to ask explicitly about prayer as a part of a help-seeking process.

Gender. Much of the access to care literature comparing men and women focuses on discrepancy in use of services (e.g. Ojeda & McGuire, 2006; Wamser et al., 2011), noting

that women across ethnic groups and socioeconomic statuses tend to access care more than their male counterparts. This study primarily explored the process rather than outcome of seeking help. Though the same underlying process emerged for both men and women, the findings indicate vast differences in how Orthodox Jewish men and women in Jerusalem look for and receive help.

When women in the study sought an external resource, the first call was to a family member or friend. In two cases, younger women called a mentor (both cases that required confidentiality because a significant other was involved). The consultation of a religious figure was often secondary or tertiary to family and social support for women. For men, the consultation with a religious figure was often primary or secondary. This was more true for men involved in full-time or part-time Torah study (it is a value emphasized in that environment and Rebbeim are often accessible in those environments). Men who worked full time tended to describe an independent help-seeking process, often involving information-gathering and sometimes minimization. If these men consulted a religious figure, it was after some attempt at self-management of the stress.

These findings support Franks et al.'s (2005) assertion that cultural groups must be looked at individually, that a blanket statement that 'women are better than men at negotiating pathways to care,' though true for many groups, is not so for all. When self-management of stress and non-traditional helpers (i.e. not professional mental-health or medical health resources) are considered, help-seeking frequency may look more equal. Men in this study reported the same process as women, but tended toward seeking Rabbinic figures and/or independent stress-management. The findings did not suggest that men fit into the avoidant category more than women as stereotypes might suggest. They explained an emphasis on

independent stress management, but did not describe themselves as characterologically avoidant of help more or less than their female counterparts.

When couples in this population experience stress together (such as a medical issue with a child), there appeared to be a tendency for men to let their wives do a lot of the help-seeking on behalf of the couple. Three separate men in their interviews began using the pronoun "we" without clarifying who else was involved in their help-seeking process. Only when asked to clarify who else was involved did each one explain the role of a wife in their help-seeking process. All three men described family situations where, without explicitly deciding to do so, their wives initiated the process of networking and reaching out to community resources. Because the women were responsibly involved in this process, the men were left with only the independent management process to negotiate on their own. This indicates that some discrepancy may be due to the role of marriage. If a wife is contacting community resources willingly, the husband does not need to. Because all of the participants in this study were married, I cannot comment on what help-seeking might look like for single men in this population.

Koopmans and Lamers (2007) looked at mediating factors that may be causing differential use of medical healthcare in the Netherlands. They found that though men and women reported relatively equal propensity to seek care, they differentially reported mental distress and somatic morbidity. The difference in experience of mental and/or somatic distress, they propose, is the mediating factor causing women to seek help more than men.

In the context of the nine-stage model proposed in this theory, these finding might suggest one of two possibilities: (1) Men and women experience stages one and two differently (emotional experience and cognitive assessment; i.e. they are actually feeling and

cognitively processing the stress differently) or (2) that the help-seeking filter is different for men and women and the filter "colors" the self-reporting of mental distress and somatic morbidity. If women tend to be more prone to a reaching/anxious help-seeking pattern (this is a hypothetical, not a direct finding in this study), they may be prone to, in retrospect, evaluate their past distress as higher to justify or help explain the help-seeking pattern they chose.

Psychosocial Barriers.

Stigma. This study confirm's Vogel et al.'s (2007) assertion that self-stigma is a greater indicator of help-seeking than public stigma. Vogel et al. found that perceptions of public stigma contributed to the experience of self-stigma, which, in turn, influenced help-seeking attitudes and eventually help-seeking willingness. Self-stigma mediated the relationship between public stigma and help-seeking behaviors in their study. Participants in this study often described an awareness of some degree of public-stigma, but only one participant noted internalized stigma directly influencing her ability to seek help. I discuss the implications of this finding further in the section below on "Population specific research."

Negative attitudes toward treatment and mistrust or fear of system. For the population under study lack of perceived need and attitudinal barriers to care were often mentioned. Because this was a non-clinical population, it is difficult to know whether this perception was accurate or not. In a population of suicidal patients, Bruffaerts et al. (2011) reported lack of perceived need as the most important reason for not seeking help (58%), followed by attitudinal barriers such as the wish to handle the problem alone (40%). Kessler et al. (2001) found that 55% of National Comorbidity Study respondents with severe mental illness reported that they did not believe they had a problem requiring treatment. Others in the same study reported a perceived need but simultaneous belief that they should try to solve

the problem on their own. It is difficult to know from the sample of this study what role negative attitudes toward treatment play in the help-seeking process. Certainly for those with an independent/avoidant help-seeking filter, especially those for whom it was ego dystonic, these negative attitudes were explicitly cited as a barrier to care.

Only one participant explicitly spoke about mistrust of psychologists, particularly secular psychologists. He spoke about a lack of genuine caring and the motivation for payment as his reasons for mistrust. Interestingly, he included in his interview that in his role as a teacher and mentor he had more than once referred students and mentees to therapy. A study specifically targeted at perceptions of mental-health resources for this population would clarify the role of negative attitudes about care and general mistrust or fear of mental-health systems.

Structural Barriers. The most frequently mentioned structural barrier was that of transportation. This has complex implications for practice; the findings of this study indicate that participants' desire for privacy might contraindicate the central location of services in religious communities. Cost and lack of knowledge about available resources were the other most frequently cited structural barriers. Lack of health insurance, a major barrier cited in the US literature (Franz et al., 2010) was not cited by any of the participants. Israel has socialized medicine; thus, all participants had health insurance at the time of the interview. The national health insurance, however, rarely covers non-psychiatric mental-health costs. Even so, participants mentioned cost rather than lack of insurance coverage as a structural barrier.

Attachment. Consistent with grounded theory, the hypothesis that attachment might be a major influence in help-seeking, emerged directly from the data. Although, in retrospect,

this connection seems somewhat obvious and has been explored in the literature, I did not include it in the literature review of my proposal or think to ask about it explicitly in the interviews (I did ask explicitly about learned messages). The results of this study support the idea that attachment style should be considered in future research studies on help-seeking. Vogel et. al (2005) quantitatively explored the relationship between avoidance and attachment in help-seeking and called for a more qualitative approach, suggesting more research is needed to understand how attachment influences help-seeking. This study did not specifically look at attachment in a way that informs that question. It does, however, support the idea that in adulthood a help-seeking filter exists that seems related to attachment; it also adds support to the assertion that future qualitative research exploring the relationship between attachment and help-seeking would be a valuable contribution to both attachment and help-seeking theory. The employment of an adult attachment inventory might help elucidate the connections between adult attachment and help-seeking behavior.

Immigrant Status. Few participants mentioned immigrant status as a major barrier to their help-seeking process. In contrast to much of the literature on immigration and help-seeking from the US, English-speaking immigrants to Israel often move with greater financial resources than the general Israeli population and thus do not face some of the problems and stigma associated with low socioeconomic status in addition to immigrant status. The government also provides funding for five months of language study including living stipends if the individual formally declares citizenship.

Participants did note that distance from family who continued to live in their country of origin was particularly difficult in times of crisis. Several participants recalled difficult times when family flew to Israel to be a support. This population may differ from other

immigrant populations studied in the help-seeking literature (much of the literature is on Asian and Latino populations in the U.S.; e.g. Chung, 2009) in that this population is not under-privileged. Though many participants spoke about difficulty being away from family, in times of severe emotional stress, they often mentioned that family flew in. Three participants noted language being a barrier when interacting with medical health services. Participants also noted lack of knowledge about available resources as a barrier, but did not necessarily attribute this lack of knowledge to immigrant status; rather, participants pointed to a general lack of availability of this information.

In order to understand the immigrant process for this population a study with narrower criterion for duration of stay in the country or a design that accounts for time in the country would be necessary. Participants in this study ranged in duration of residence from two to 31 years with an average of 13 years (SD=10 years). Some participants did talk about a more reaching/anxious help-seeking filter during their adjustment period to the country; looking at changes in help-seeking during the initial years of immigration would likely add significant information to the impact of immigration on help-seeking for this population.

Therapist match and culturally competent care. In 1996, Liddle suggested that the literature on therapist match and culturally competent care focus more on culturally competent care. He acknowledged that most ethnic groups have a preference for therapist match (confirmed by more recent literature; Cabral & Smith, 2011), but argued that the literature is intended for clinicians who cannot change their ethnic status, but can change cultural sensitivity. Schnall, E. (2006) wrote a chapter, "Multicultural Counseling and the Orthodox Jew" for the Journal of Counseling and Development intended to inform non-Orthodox clinicians about Orthodox clients. He notes the importance of this work, stating

that many Orthodox clients prefer non-Orthodox therapists for reasons of privacy. Although this may be true for the population he works with (in New York) or for smaller communities where the likelihood of coming into social contact with an in-group therapist is high, this did not appear to be true for the population studied in Jerusalem.

The findings of this study indicate that for English-speaking Orthodox Jewish immigrants in Jerusalem a value match is of utmost importance. Most of the interviewees who mentioned going to professional mental-health resources spoke about the importance of knowing that they could trust the professional's values (religious values was often the implication). This information was important enough that it was volunteered (it was not asked about explicitly in the interview). Liddle may be correct that, in general, studies of therapist preference may not have the same utility as studies that have the potential to educate clinicians about important cultural sensitivities; for the population in this study, however, going to a non-religious therapist seemed unlikely. Thus, future literature geared toward helping in-group clinicians become more culturally sensitive and aware may be of greater utility than literature geared toward informing clinicians outside of the community.

Population-specific research. In contrast to Rosen et al. (2008)'s assumption that underutilization of mental-health services at the Herzog medical center is due to stigma, this research indicates the underutilization is likely much more complex. Participants in this study did not talk about lack of availability of resources within the community (although some did describe difficulties finding and accessing them); the process and preferences they described indicated a relatively insular (within the Orthodox community) approach to dealing with emotional stress. The issues of value match and privacy also contraindicate this population choosing to go to a non-religiously affiliated public mental health center located in a

religious neighborhood.

Participants also described privacy differently than they described stigma. Stigma was often discussed as public-stigma, the perception that the community thought of people who sought professional help as somehow less-than; privacy, however, was described as a general value that the need for help should be expressed only to those who could provide help or access to it. Participants, particularly women, discussed having one or two confidants who they might "vent" to, but expressed an overall value not to speak to too many people about a particular issue. Again, this was not expressed as a fear that others would think less of them (stigma), but was expressed as a general value or preference.

Implications for Practice

The constructed model and corresponding theory focus primarily on the process individuals use to seek help in times of stress. There are thus, more implications for community education and provision of services than clinical practice. There are, however, some implications for clinical practice; experiences and preferences participants shared about their interaction with professional mental health services.

Community education. It may be helpful for those developing programs for public education about mental health resources to consider the three types of help-seekers. In any given audience there may be those with the underlying assumption, "professional help is a last resort" (independent/avoidant), "in stressful times all available resources should be consulted" (reaching/anxious) and "I will incorporate the knowledge about these resources into the successful help-seeking network I already use" (supported/secure). Again, these are general categories that are more likely a spectrum than distinct and separate. This conceptualization may help when developing public presentations; it may be appropriate to

include a portion on when it is appropriate to seek help from a professional, when it is premature to seek professional help, as well as the details about what help is available and how to access it.

Developers of community education and providers of services might also want to specifically address some of the noted structural barriers. Information about transportation options or subsidy for transportation may be particularly helpful. Low-cost options for care is also important information. Acknowledging and validating a desire for privacy would also be reassuring for community members. It may be helpful to explain laws and limits regarding confidentiality and describing care options that are accommodating to privacy (private therapy or clinicians that are part of larger organizations, e.g. a women's clinic that provides medical as well as mental-health services).

This population cited the importance of a trusted referral source. The implication of this finding indicates that a mental-health referral source similar to the medical referral source mentioned by participants (a Rav in the community who has compiled a list of the top medical professionals in various areas of specialty) might be a helpful point of access. The findings also indicate that, especially for men, the facilitation of contact between clinicians and Rebbeim might help broaden the care available to the community.

This study suggests important implications for community education in relation to gender differences. Men and women described very different points of access to care. The findings indicate that for men, educating Rabbis about available resources would be a more efficient approach than addressing large groups of men in some other forum. The men in this study reported a Rav as the primary point of access to care. For women, however, more general population education might be helpful; the primary point of access to care for women

was more often a family member or friend. A community lecture for women about available resources would likely be much more effective than a similar lecture for men.

In a broader sense of "community education," this study indicates the importance of educational opportunities for potential Orthodox mental health care providers. The findings of this study for this population indicate that for many individuals going to a clinician who they do not believe is a value-match, is perceived as a non-option.

Clinical Practice. The model that emerged from this study indicates that there is a multi-stage help-seeking process and often several resources accessed before a mental health professional for this population. Therapy may be part of a long-term help-seeking process, or the first resource accessed for this stressor. It may be important for client conceptualization to understand the client's process before entering the therapy room: Which of the help-seeking filters did this client use? Is the clinician one in ten resources accessed, the first and only resource outside of the referral source to be consulted? Perhaps most important as expressed by the participants: Who is the referral source?

The importance of a referral by a trusted individual was emphasized by many participants. If the referral source is a Rabbi or Rebbetzin, the clinician may want to ask the client if he or she would like there to be contact with this religious figure during therapy. For some, that may help them feel that the clinician is in contact with and consulting the person he or she most trusts in life-decision making, for others the values of confidentiality and privacy may be more important than that this type of contact.

The co-researcher on this project noted, when asked about how her participation in this research would influence her treatment of an Orthodox Jewish client, the importance of having a cultural informant and/or contact with a Rabbi. She explained that the decision

making process seemed markedly different than the clients she is currently seeing in that (1) there tended to be trusted individuals and support for the participants, and at the same time a hesitance to share the emotional stress with an extended support network, (2) the role of religious figures and mentors seemed to be extremely important in decision making and (3) the gender differences seemed vast (she did note that she could not imagine an Orthodox Jewish man wanting to see her as a clinician). For a clinician outside of the religious community (which, in contrast to the findings of this study, Schnall et. all, 2006 suggest is common and often preferred by Orthodox Jewish clients in the US) a cultural informant and contact, when possible, with the client's Rabbi may be very important. This population does have several distinct value and decision-making patterns that need to be understood both to establish trust and rapport, but also for general treatment; it is important for a clinician to know what is normative and atypical in the client's world in order to best conceptualize the client and form treatment goals.

Participants who mentioned unhelpful therapy experiences often explained that the help was not "practical." This complaint may be influenced by an expectation that a psychologist or social worker will help in the ways that family, friends or religious figures help. Clients from this population may expect more guidance or advice and may need more psychoeducation about why talking about emotion or past experience is "practical." Cognitive behavioral models might be easier to understand without extensive psychoeducation, where a psychodynamic approach may require some explanation in order for the client to choose to stay in therapy.

Finally, mental-health care providers for this population should take into account the structural barriers listed by participants. Because transportation was so often cited as a

barrier, it is important to consider when making or accepting referrals where the person lives, whether or not he or she has a car (many living in Jerusalem do not) and whether the cost and time of transportation will ultimately prohibit continuity in the therapeutic process. A sensitivity to privacy may also be important. It may be more important for individuals in this population than others not to be seen in a waiting room by other community members. Many participants also noted that it was difficult to know how to find a good therapist. It is likely that a client found a clinician through a single trusted referral source and has no knowledge about other available resources. Clinicians serving this community may want to inform themselves about the available mental-health resources in order to make appropriate referrals.

Limitations

There were several limitations that affected the results of this study. First, only 11 individuals responded to the participant check. Participants were asked on their demographic questionnaire if they were willing to receive findings and provide feedback. Twenty-two of the 26 responded that they were willing and provided either an email or home address. Nineteen of the 22 agreed to be contacted by phone to collect feedback. Even with personal phone calls, only 11 individuals responded (I called twice and then considered a non-answer an indirect communication that they did not want to participate). In a future study I would make clear that participation includes both an interview and feedback. I would not discount an interview where the participant later chose not to give feedback, but I do think making it a clearer expectation of study participation might have been helpful.

Another limitation is that I could only interview individuals who would consent to be interviewed. Those most concerned about stigma or most resistant to seeking outside help were likely not included in the study. Only one person directly told me she did not want to

participate, telling me, "I'm not good for the study anyway. I probably don't look for help like other people here do." Others simply did not return my phone call or told me that they were not available for an interview the days of the week I was available. Additionally, I asked participants to contact anyone they thought might be interested in participating and later called to see if their friend or relative consented for me to have their phone number. I do not know how many people said "no" to my calling.

Snowball sampling has some inherent limitations: Initial participants tend to nominate those they know well; often these new participants share traits and characteristics with the participant who referred them (Charmaz, 2006). Thus, the research may only get a small sub-group of the population sampled. Because of my in-group status, I was able to begin with some of my own contacts (a friend, a former teacher, a neighbor and a co-worker) and consciously chose those representing different sub-sections of the population. Still, within those groups, the bias inherent with this type of sampling was a limitation.

The organization of the study's interview protocol could also be considered a limitation. I began with a broad question allowing the interviewee to structure his or her account of help-seeking, but for those who sought more direct questions and guidance, I asked about their process in a chronological way, asking what was and was not helpful at each stage. This may have influenced the development of the stage model. I also changed the interview protocol twice (after a total of three, then seven participants). Thus, only the last 19 interviews reflect the same protocol.

My own in-group status is both an asset and a limitation. While I am very familiar with the population, connected in the community, and likely a comfortable person for participants to talk to, participants may also assume that I understand certain values or norms

that they might explicate for a non-community member interviewer. I was not raised in the religious community and thus, may not always have an implicit understanding of the values or norms the participant is referring to. Where I was aware that I did not understand, I asked clarifying questions; there may, however, have been times where I assumed I understood, but did not. I also carry my own opinions and biases about the community. I attempted to acknowledge these through use of a reflective journal, memos and reliance on a non-community-affiliated research assistant and external auditor, however it is difficult to be fully aware of all biases and these biases may have influenced the interviews.

Three different interviewers were employed in this study: myself, a male interviewer and a female interviewer. As the interviews progressed, I became more experientially aware of what constructivist grounded theorists mean when they talk about the "co-construction" of meaning. My own emerging awareness of the process being described and the details being shared shaped my follow-up questions. For example, as the difference between men involved in Torah education and men involved in full time work emerged, I asked more follow-up questions to working men about how they handled the emotional stress before contacting a Rav (because this part of the process was markedly different for this sub-group). Only after reflecting and writing did I realize I was doing this and informed the male interviewer to do the same. Because he was not involved in the data analysis, he stuck more strictly to the interview protocol; his interviews were not changing subtly as theory emerged as mine were. The choice to use a male interviewer was the choice between the limitation of a second interviewer or limiting the study's male participants to those comfortable with a female interviewer (this is not always culturally appropriate). The secondary female interviewer conducted two interviews that were markedly shorter than any of the other interviews

collected. It was difficult for her to remain process rather than content oriented. I chose to keep the two interviews as part of the study, but chose to interview other women in the study myself.

Socioeconomic status as well as family and family of origin size were not asked about on the demographic questionnaire. This study cannot make any statements about the role of socioeconomic status or family size and help-seeking for this population.

Finally, the term "Orthodox" is a very broad term. Interviewees ranged from those with very little contact with secular culture (no television, internet or access to secular media other than the occasional billboard) to those working eight hours a day in secular environments who likely read secular newspapers, have regular internet access, and friends and family who do not identify as Orthodox. The participants represent a very wide range of world views, values and influence. Specific research about Modern-Orthodox, Yeshivish-Orthodox, and/or Hassidish-Orthodox might be valuable to better understand these distinct groups. These groups themselves, have a wide range of subgroups.

Conclusion

This study focused on the question: What is the process that Orthodox Jewish English-speaking immigrants in the Jerusalem community use to seek help in times of emotional stress? A 20-30 minute semi-structured interview was employed and a qualitative, constructivist grounded theory approach used in the collection and analysis of 26 interviews. The result is an attachment-informed nine-stage cyclical feedback model of help seeking as well as a detailed description of the decision making process for participants at each stage. This process and the rich data that inform it have important implications for theory, research, practice and education.

I noted in the introduction that this study was a personal journey to better understanding the community in which I live and work. Overall, I found that individual difference is vast. People are neither overwhelmingly suffering in silence nor feeling that they are well-supported and know exactly where to go in times of emotional stress. The theory that emerged will inform my clinical practice and my involvement in community education and outreach. I have an understanding that only qualitative research can provide about the complexity of the help-seeking process in my community.

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Appendix

A. Demographics: Questionnaire and Participant Demographics

B. Semi-Structured Interview Protocol: Initial, Second and Final Protocols

C. List of Line-by-Line Codes

D. List of Final Focused Codes

E. Theoretical Coding Flow Chart

F. Participant Check Document

Appendix A. Demographic Questions

Researcher will note outwardly expressed gender identity.

1. How old are you?
2. What is your occupation?
3. What country were you born in?
4. How do you identify ethnically?
5. How do you identify religiously?
6. Do you identify as Baalei Teshuva?
7. How many years have you been living in Israel?
8. Did you make Aliyah?
9. What type of health care coverage do you have?
10. Would you be interested in receiving a summary of the findings of this study and giving feedback about the conclusions?
    - If so, what email or residential address would you like it sent to?
    - If so, can I call you to get your feedback about the findings?
        - What phone number can I call you on?

Appendix A. Participant Demographics:

Pseudo-nym	M / F	Age	Occupation	Religious Identifica-tion	Baalei Teshu va	Yrs. In Israe l	Aliyah
Beth	F	56	Teacher,	Orthodox (Charedi)	Y	29	Y
Chani	F	36	Mother	Jewish	Y	11	Y
Bracha	F	29	Tourism, Mom	Orthodox	N	7.5	N
Rivka Gittel	F	21	Teacher	Orthodox	N	8	N
Gitty	F	43	Homemaker	Chassidish	N	24	Y
Naftali	M	25	Educator	Orthodox	Y	4	Y
Susan	F	62	Office manager	Jewish Orthodox	Y	10	Y
Racheli	F	35	Doula, mommy	Jewish	Y	4	Y
Yosef	M	36	Teacher, Rabbi	Charedi	N	17	Y
Nancy	F	35	Teacher, Counselor	Charedi	N	33	Y
Eden	F	28	Non-profit, Mom	Orthodox	N	3	N
Michal	F	27	Babysitting	Ultra religious	N	27	Y
Noson	M	62	Teacher	Charedi	N	37	Y
David	M	51	Talmudic Student	Charedi (Ultra Orthodox)	Y	25	Y
Alex	M	26	Talmudic Student	Jewish Authentic	N	8	Y
Bob	M	37	Kollel, tutor	Jewish	Y	15	N
Rebecca	F	26	Babysitting	Orthodox	N	6	N
Aaron	M	28	Yeshiva student	Jewish	Y	5	N
Nathan	M	61	Teacher	Charedi	Y	31	Y
Shoshana	F	24	Mental health aid	Orthodox	N	3.5	Y
Shmuel	M	33	Kollel student	Orthodox Jewish	N	15	Y
Candy	F	65	Doula	Orthodox	N	2	N
Talia	F	50	Marketing	Orthodox	Y	3	Y

				Jewish			
Chanuch	M	34	Therapist	Orthodox Jewish	N	11.5	N
Moshe	M	43	Biotech	Orthodox	N	20	Y
Alan	M	43	Attorney	Orthodox	N	5	N

Appendix B. Initial Semi-structured Interview

Opening: The purpose of this project is to better understand where English-speakers in the community go for help when they are under significant stress and what tends to be most and least helpful in those times.

1. Grand Tour Question: Think of a time you were under significant stress. Can you tell me about how you handled it?

    Prompt: Did you seek help from anyone?

        If so, who?

        If not, what prevented you from asking for help?

2. So you said you asked ...for help. What was helpful about....What was not helpful about...

3. Were there any barriers in your process? If so, what were they?

4. Is there anything you would have done differently?

5. Is there anything else you would like to add that you think would help me understand your process of dealing with that stressful situation?

6. What messages did you get about who to ask for help when you were growing up?

7. Is there anything else you would like to add?

Thank you for your time...Do you know anyone else who might be willing to participate in this study?

Interview Revised (Aug 2013)

Opening: The purpose of this project is to better understand the process English-speakers in the community use to get help when they are under significant stress and what tends to be most and least helpful in those times.

1. Grand Tour Question: Think of a time you were under significant *emotional* stress. Can you tell me about how you handled it and how you decided to do what you did?

Prompt: Did you seek help from anyone?

If so, who?

How did you decide to do what you did? (Thoughts, feelings...)

If not, what prevented you from asking for help?

2. So you said you asked ...for help. What was helpful about....What was not helpful about...

3. Were there any barriers in your process? If so, what were they?

4. Is there anything you would have done differently?

5. Is there anything else you would like to add that you think would help me understand your process of dealing with that stressful situation?

6. What messages did you get about who to ask for help when you were growing up?

7. Is there anything else you would like to add?

Thank you for your time...Do you know anyone else who might be willing to participate...

Interview Revised (Oct 2013)

Opening: The purpose of this project is to better understand the process English-speakers in the community use to get help when they are under significant stress and what tends to be most and least helpful in those times.

1. Grand Tour Question: Think of a time you were under emotional significant stress. Can you tell me about how you handled it and how you decided to do what you did?

Prompt: Did you seek help from anyone?

If so, who?

How did you decide to do what you did? (Thoughts, feelings...)

If not, what prevented you from asking for help?

2. So you said you asked ...for help. What was helpful about....What was not helpful about...

3. Were there any barriers in your process? If so, what were they?

4. Is there anything you would have done differently?

5. Is there anything else you would like to add that you think would help me understand your process of dealing with that stressful situation?

6. What messages did you get about who to ask for help when you were growing up?

7. What are the ideal steps a person should take to get help in a time of stress? (If you had to tell someone who looked up to you how a person *should* look for help, how would you answer?)

8. Is there anything else you would like to add?

Thank you for your time...Do you know anyone else who might be willing to participate in this study?

Appendix C: List of Line-by-Line codes.

- Acceptance
- anxiety
- appreciating
- barriers
  - cost
  - lack of sleep
  - lack of support system
  - lack of time
  - not knowing who to call
- being practical
- calming down
- challenging
- cleaning
- comparing to other experiences
- comparing to others
- complaining
- complaining to others
  - husband
  - mother
  - sister
- counseling
- dealing with it
- denying need for help
- doubting
- feeling agitated
- feeling bad
  - high blood pressure
  - lacking strength
- feeling fine
- feeling good about what I did
- feeling hysterical
- feeling scared
- feeling supported
- feeling understood
- friend
- getting information
- getting perspective
- good quotes
- growing
- having a support system
- having knowledge
- helper unavailable
- hypotheticals
  - what was lacking
    - personal connection
    - practical
- internalizing
- joking
- keeping it a secret
- kids
- learned messages
  - childhood story
  - not wanting to do something wrong
  - parent message—don't ask for help
- explicit
  - parent message—don't ask for help
- implicit
  - parent message—positive
  - parent—okay when desparate
  - positive parenting
  - wanting to be independent
- letting go
- level of education of helper
- making due with what you have
- making others crazy
- marriage
- medication
- minimizing
- moving on
- music
- normalizing
- not dealing with it
- not discussing with others
- perceptions of religious community
  - okay to ask for help
  - supposed to ask for help
  - unacceptable to ask for help
- personality
- positive self-talk
- praying
- reaching out
  - blog
  - counseling
  - cousin
  - doctor
  - emergency medical services

Appendix D: Focused Codes. Sent to external and internal auditor.

1. Response to Stressor

This code is used to identify how the person responded to the stressful situation. Subcodes were created for external (what did the person do, in action) and internal responses (cognitions and emotions) and also for first response (what did the person do first).

External Response

"OK, so I put it into perspective, which helped me a lot. Meaning, I'm following two people's blogs right now on the Internet, two children who are very sick in LA. I read their blog every morning and every night, and it talks about the treatments they're going through, and whatever, a very difficult situation for both families." --Bracha

"I spoke to two Rebbetzins and I had a short and unsuccessful round of counseling, or unhelpful, not even unsuccessful. It was just kind of silly." --Chani

"I did more things for myself. Exercise helps me a lot when I'm dealing with stress. And talking to other parents, again, who went through similar things."-- Beth

"OK. In terms of actions that I did, in having to deal with them[difficult neighbors who were making threats], everything was just asking Da'as Torah (Rabbis who are very well learned in all of Torah), I had to ask the dayanim (judges) on the beis din, I asked my Rosh Yeshiva (head of where he learns Torah), I asked a posek (someone who you go to with questions relating to Jewish law)." -- David

Internal Response

"I really only get calmed down if at the end of the day, I come to the realization myself, or I talk to myself. That's my biggest way of getting out of whatever situation I am in." --Bracha

It was a nightmare. I was so stressed out by it. I was at a point where I didn't know how to deal with it. It was too out of control. --Rebecca

I think I also did a lot of just thinking about myself personally. What does it say about me? What do I fit, what do I not fit? Things were swimming inside.-- Chanuch

At that point, I had three little kids. It just got to be too much to be the person that was married with three children, having a job, dealing with siblings that needed emotional support, and dealing with my own emotional distress. Dealing with the process, at that point when I broke down in tears to my friend, it was because it was just too much.-- Nancy Goldstein

First Response

"I'd say, the Rav is always first, our posek (Rabbi of Jewish law) especially the one who helps us make decisions, who knows the family situation, who knows where

we're coming from, who knows where we're going, who has helped us until here, who knows our emotional background, and what could be an issue for us. We for sure go there first, and he's always the most helpful. You definitely leave there knowing that you're much more settled and you know you're doing the right thing." --Rivka Gittle

I think I actually spoke to my husband first. --Eden

Me personally, the only thing I felt that I was able to do was to go to a very big Rav (Rabbi). That was stressful. I was talking to my wife about what the right thing to do. We couldn't figure it out together. I went to Reb Aaron Leib (well-known Rabbi), which was a very interesting conversation. He's a very busy person, but he gave me 15 minutes of his time. --Yosef

Oh well, the first go to was to denial [laughs] . That was standard. --Chanuch

2. Description of Stress
This code is used to label the participants description of the stressful situation he/she is referring to:

"K. When I found out that the kids had pinworms pretty recently, it was stressful because I get a little bit obsessive about cleanliness, or things that are contagious and stuff like that. Compared to other people's stresses, this might sound very insignificant, but for my type of personality, this is very significant." --Bracha

" I was under significant emotional stress right before my wedding, when I was also finishing basic training in the Army. I didn't know where I was going to be stationed finally. I didn't know if I was going to be able to come home every night or only on weekends. My wedding was only two weeks away..." – Naftali

"Recently my son had to go into the hospital. He was having an operation on his skull. It wasn't life threatening. Having to deal with the Israeli health system, being an English speaker, and having to help my wife, just doing most of that stuff. Being an English speaker, not having your parents around-- this was the first time I was ever in a hospital for a long period of time. It was all the way in Telaviv. We live in Jerusalem. So that was very stressful. And we were there for a week. I'd never had an overnight stay in a hospital. My wife did for the baby but this was for both of us the first long term stay at a hospital."--Aaron

3. Working Model of Help-Seeking
Codes for the assumptions a person carries about how help-seeking should work. This code replaced "perception of resources" and the code "ideally;" these codes became redundant after adding this concept of a working model or filter. This code is the present lens the person views help-seeking through; it is different from the code "learned messages" in that learned messages has a past-orientation and may or may not be incorporated into the person's present working model.

“When something big comes up, the first address should be a rabbi or another gadol (someone well known who is well learned in all of Torah) to help you make a decision.*”*--Yosef

“I think that a person really needs to define what they need help with. Some people are going through a situation and they're so disorganized in their head, what's going on. They don't even know how to translate anything. They're just so confused. I am a proponent of writing things down to clarify what is your issue? What are you trying to figure out, and what are your questions?...I'd speak to someone who knows you, who you actually think they know you. There are so many professionals in the world. Yes, professionals can help even if they don't know you, but I think there is something extra, something better about going to someone who actually knows you because they care about you. They have your interests [in mind], you hope. Hopefully they will help you more than someone who doesn't know you at all, I think.”-- Shoshana

“I'd say things like the Gemara [the oral Torah] says: speak things out with people. Speak it out with someone you really look up to, someone you really look up to, and you think this person is living life the proper way, and you admire them, and seek help from them, see what they would suggest.” --David

“I'm pretty open about getting help. I think most people in the Haredi [ultra-orthodox] community are not. We're very secretive. We're always scared that something is going to effect our shidduchim[dating] or our name in the society that we're in. I think it's important to have the support system before the problem happens. I think that's what I learned the most in OA, is having that support system lined up in a benign way that when something happens I should have that support. Also, just learning who to trust for what. That's important for me, too. I'm very happy I have this cousin of mine because she's amazing. I could tell her anything. Anything. Everything and anything and that's amazing. I'm not your traditional chasidisha [Hassidic] lady, I know. [laughs] I used to be a lot more open about everything. I've closed up a lot more because I found that things come back and hurt me. Being too open wasn't good, either. I pick and choose my people nowadays a lot more than I used to.”--Gitty

4. Learned Messages

Messages participants picked up in childhood and/or perceive as their current community's perspective on help-seeking. Subcodes for “childhood community,” “family of origin,” and “current community,” are used to differentiate the source of the message. Messages that participants did not give a source for or said were consistent across sources we coded under the general category "Learned Messages."

“I think the message of someone that you trust and someone that you admire was pretty constant. I think I always lean more toward a combination of both, not just someone that I trust. I trust people that...I don't want my life to be like theirs, so why would I ask them for help?” --Racheli

"I grew up in an environment where therapy was accepted, where seeking help for things like this was accepted. It's not considered a weakness."-- Naftali

"I don't think I wanted to ask for help. I think I wanted to do things by myself. I don't think that was...I don't know if that was communicated by my environment or not, or if that was just my own thing. I didn't want to do something wrong, but I don't know if I wanted to ask for help."-- Chani

Childhood Community

"You feel the importance in high school. They always say, 'We're there for you. Talk to us. We understand.' But until I actually found somebody...It was important to me, but I didn't have anyone. The schools send out those messages. It doesn't always work. But you do feel the importance of having someone." --Rivka Gittle

"I got the message in Yeshiva-- Try to get yourself a Rav, try to find somebody you trust-- not really pushing anybody on you. Nobody's going to come out and become your Rav. You need to do the work. You need to kind of go up to him and make conversations." --Aaron

Michali: "I didn't get messages. When I was growing up, I didn't get messages. Not in my days, no...they never talked about help. I don't remember having messages, no.
Ilyssa: From school, from your community?
Michali: You don't know where we came from. We came from drip land.
Ilyssa: What does that mean, drip land?
Michali: Very plain. Every day we had to just be good. I don't know what people did with problems. There wasn't the profession that there is today, and certainly not in the religious community. There wasn't. How many religious psychologists were there? There weren't. When I grew up, I didn't know about them. You just lived with your issues. That's the message I got.
Ilyssa: You just lived with your issues?
Michali: Unless you did deal with the issues.
Ilyssa: Were there any messages about non-professional help? Who to go to -- parents or teachers? Or the message was just, you live with it?
Michali: I feel in my particular upbringing it was basically just live with it... " -- Michal

Family of Origin

"When I was growing up. I guess I was always told to speak to someone that you trust. My parents always told me that I could talk to them about anything, but I don't think I ever wanted to talk to them about anything. [laughs] I think they showed me at a very young age that I actually could not trust them." --Racheli

What I'm doing is basically what my parents did when they had a problem.They also worked it out with each other, because they had a very strong relationship. They

asked the rabbi and then they consulted the wider family, which I don't have here, but what everybody's opinion was. After having sat on it and thought about it, they decided. --Noson

"I'm just thinking, let's say a child has a learning issue, so go to a professional, that kind of thing. Take care of that. I was brought up like that. I wasn't really brought up to ask a Rav (Rabbi). I don't know how that's probably different, but I wasn't brought up to ask a Rav (Rabbi). I was also brought up very--maybe that's also why I'm internal-- very individual. Think for yourself. You're smart enough, you're educated. You don't need other people to help you so much. I never thought about it, but now that you're asking me, both of my parents are very individual, and very much thinkers on their own. My mother also doesn't discuss her problems with anyone. She'll talk to me. She won't talk to other people. She has people who will talk to her, but she won't divulge her inner emotional issues, whatever. Maybe part of it is that I also learned those things from my parents. My father is also very internal. Both my parents [chuckles] are actually very internal. I guess I did absorb the concept that you don't need to get help from other people. My mother says it all the time, 'Don't air your dirty laundry in public. You don't need other people to know your problems.' When other people do it to her, she also is a Psych major, she's the type who connects. People like to talk to her, but it's interesting. Someone can talk to her. She has someone who she's a good friend with, who will divulge everything about her life. My mother will not divulge a thing, [chuckles] nothing. She'll listen. She's a good listener, and everything. She won't divulge anything. She has divulged things to me and she's very close to me. She's open with me, but I definitely am sure I heard those things." --Shoshanna Gross

"In my house, it was really the Rabbanim, the Rav of the community or maybe a family friend that was a Rav or something. Again, big issues. I know that my parents also spoke sometimes of one time when I was a little kid they took me to a psychologist because I was driving my mother crazy. I was like a wild animal. That was a one or two time thing. I continued driving her crazy after that, also. Besides that, that's really it, more or less." – Yosef

"Yeah, all my siblings and I all have a wonderful relationship with my parents. They were never threatening in any way. They brought us up really well, so if there was anything... Even now, I'll ask my father a question if I feel like I want his advice on things, so yeah. I think I would go with them first before anything that would come up, yeah. They were always there for us, and I felt like they are very wise, and know how to listen and know how to respond." – Bracha

Perception of Present Community

“I'm pretty open about getting help. I think most people in the Haredi [ultra-orthodox] community are not. We're very secretive. We're always scared that something is going to effect our shidduchim [dating] or our name in the society that we're in.” --Gitty

"Perhaps an Avreich (young married man) who spends his time in learning, where there's a specific focus on character development within the framework of his Kollel (group of married men learning together) or his Yeshiva (school) or his whatever, that's an important point. Some people are tapped into that, some people are not. If you're tapped into that, then I think you're somewhat equipped to deal with these types of situations, perhaps, more than let's say, someone who is not involved with such a program where there is some kind of stress and some direct work on obtaining the tools to deal with these types of situations of stress;..."– Shmuel

"What I would like to add in terms of the purpose of the study, is that there is a lot more publicity about different health organizations, which I think is great in all kinds of different areas. Also there are more tsadaka [charity] organizations that are helping. Recently I had something that I wanted a coaching for a child with ADHD. It's really important that I got some free coaching from somebody..." --Beth

"Definitely. It's not open [information about finding a good therapist]. It's not out there in the open. It's harder to network. It's harder to find them. Both because they're not as available I think, and because people are not so free with the information to be able to say, "Oh yeah, I had a great experience with this and this therapist, in case you ever need."--Nancy Goldstein

Self-Perception

Codes for statements participants made about personality, characterological traits and tendencies.

"I'm more of an internal person. I don't really discuss my problems or my issues or things that are emotionally bothering me, with people so much." --Shoshana

"I'm a social person. I have connections to people that I would seek help from, not that I did it often. It wasn't like I felt that I was a secluded type of a person, but in these stressful situations, when you don't have access to the help and it's not so available, you feel very, very alone." --Nancy Goldstein

"Yeah. I'm a shy person by nature. Today, I think different. Maybe I thought then, 'I'm going to waste my money to go and get help? I know how to do it.' Or, 'I'll just do it my way.'" --Michal

"I think that you're definitely talking to the wrong person. My wife would be much better than me because I am just like a kind of a very closed person. I don't usually reach out for people for emotional stress kind of networking, et cetera." --Moshe Leibovitz

Barriers and Facilitators

Barriers codes for environmental barriers (e.g. cost, accessibility, transport, etc.) and internal barriers (stigma, prohibiting self-talk, etc.). Facilitators, which people mentioned less explicitly in interviews, was left without sub-categories; both environmental and internal

were coded as "facilitator."

Environmental Barriers

"Getting that letter from Rav Shterenbuch was a process. I needed him to be more accessible. But there is no reason he should have been more accessible to me. That was the first time I ever approached him. But he's a godol [a great man], he's like a very big, important person. I really needed someone who had a deep understanding of family life in the world and things. I needed to know that I was getting an opinion and directions from someone that I could trust 100 percent. To get to him was a process. I had to go through all these different avenues. I had to tell people [information] that I didn't want to tell to get them to understand how important it is that I get to speak to him. I didn't want them to know. But they were standing in the way and there was no way for me to get around it without telling them. That was hard." --Racheli

"It was a bit of schlep [difficult journey] because we didn't have a car, and we were living in Beitar . Couple of times, we had to go to a couple of different places to get certain hearing inserts, go speak to different people. It was a bit of a schlep going with the hospital and stuff. Sometimes, they had a hasaa [shuttle]."-- Bob

Ilyssa: "Was there anything about going to your mom that wasn't helpful?
Eden: It's hard to remember. I mean she's not here, so as much as I can get, is on the phone." --Eden

"Again, it's not the same process [to find a therapist as it is to find a medical professional]. You have to call the people that will be willing to share whether or not they had an experience with someone, or have feedback about specific therapists. There are very few. If you want to go to the top in the professionals for specific situations there are not many. You can travel two hours once a week to the top whatever for different disorders or situations, but they're not as available, I think." --Nancy Goldstein

"It's far away from home, so you don't want to take an hour in the chair not on the couch, in the chair. Plus at least an hour commute time. I dropped away after the wedding." – Naftali

Internal/Intrapersonal Barriers

"I just felt like I didn't necessarily know the right people" --Chani

"Barriers? The only thing I would think of is...I didn't want to, I like to minimize lashon hara [negative speech about others] and minimize embarrassing people. If you don't have that barrier, then you can get even more stuff off your chest and blame people. I didn't want to make a...that would be the only barrier"-- Nathan

"I've found through my experience, that secular people can't really understand my

mindset. While I respect their knowledge, and I'm sure that it's valid, it's statistically verifiable, but it doesn't really apply to me, because it applies to people who have a very different outlook on life, which has very little in common with mine. I don't feel that their solutions are in any way helpful. They're mostly irrelevant to my life." --Noson

"I guess one of the shortcomings of replacing the family support system with the neighbor/Kollel/friends support system is perhaps that you are less open with them, and then you feel you could come to a situation where you feel people are prying on other people." --Shmuel Ben Yosef

“I felt bad for her having to deal with me...” --Gitty

"I guess in the beginning, I felt with my sister just like really not embarrassed, because we're very close. But it could be in the beginning , like maybe if another sister came during that time period to Israel and she stayed by me, I know I wouldn't have told her because I was a little bit...I don't know why I was embarrassed, but I was. I was embarrassed. I knew that it wasn't my fault, for Racheli [my daughter, who was having toileting problems], at one point it wasn't her fault anymore. But I was a little bit embarrassed. I just wanted to keep it as quiet...You know how it is, more people just, whatever...I guess just the embarrassment would have stopped me from telling more people, or whatever."-- Rebecca

Facilitators

"I think the situation was handled as well as it could have been. There were organizations that made it a lot easier. It could have been harder if the Rav didn't tell me all of these organizations that were around."-- Aaron

"I also know she's a safe person to talk to because she's an OA and we're very, very serious about our anonymity. I wasn't worried about it getting out there in the street or something." --Gitty

"I"m trying to think. Pretty much with her encouragement, because she had experience with this specific therapist and it was very helpful for her. Her encouragement is really what got me to actually making the call and making the appointment and go. It was definitely helpful." --Nancy Goldstein

"We're very close. I know I can always call my sister."-- Rebecca

Resources

Codes for resources participants were and were not able to find and their availability. Helpfulness of resources was coded for under “Perception of the Helper.”

Available

“Yeah, she's my main mentor from Neve [the seminary Racheli attended] and pretty

much just spoke on my concerns. She had known girls who had gone through similar situations...she was really there for me." Racheli

"At that point, when I did that, it [information about therapy] was just starting to be a little bit more available, common, open. This friend really encouraged me. That's really what made the turning point for me. I really didn't think about it before. I was busy helping [laughs] other people. It wasn't in my awareness that this is something that you do, unless there's some crazy, major, crisis. [chuckles]" –Nancy Goldstein

"...No, because I had a support system. I had my people lined up who I use on a regular basis, who I talk to. Maybe I use them, I don't know. I have an amazing support system. I speak to these people on a daily, weekly basis. When I have a problem, I just call them automatically. I don't even think of who do I need to call. I have my people."-- Gitty

"I have a sister who lives here. My parents also came before. He had his Bris [circumcision] around Shavuos [a holiday], so they came then also. When he had his Bris, my father did the Bris. Then he helped when we moved back home right afterwards, out of the hospital he was there. He calmed a lot of the things down, just because we knew other people were there to help, even though we did have a lot on our plate, we also had some help. That was also helpful to know we weren't alone, having to deal with a lot of the technical stuff. – Chanuch Freidman

Unavailable

"I actually tried him [a doctor], but he was out that day, I think. I think it was a Thursday night, and he was out. He wasn't there on Friday or something like that. I asked him afterwards, but by then I was already joking about it. I was already past that point...!" --Bracha

"I'm trying to think. I tried to reach a different teacher who was really not available. I wasn't able to reach her. She is someone I really would trust, that I know what she would say. She would tell me not to go along with it."—Shoshana

"Definitely. It's not open [information about therapy and therapists]. It's not out there in the open. It's harder to network. It's harder to find them. Both because they're not as available I think, and because people are not so free with the information to be able to say, "Oh yeah, I had a great experience with this and this therapist, in case you ever need." --Nancy Goldstein

Perception of Helper

Codes for participants' impressions of those they reached out to for help. Although coded, "helpful" and "unhelpful," the descriptions include characteristics that influenced the interviewee to seek help or not seek help from the individual, not only actions or advice they found helpful.

Helpful

“Yes, I think because I look up to her a lot. I love her. I think she's incredible. I would love to turn out just like her someday. She's really incredible. She has a really big family. She started later in life having kids. She got married at 27, has this huge family, and is such an important part in so many people's growth process. She's a strong, capable woman that makes everything look graceful. She doesn't hide that life is hard sometimes and things are challenging, which I really like. She's relatable but she's always like, "Look. You get through it. It's another day." Also, I think that knowing her job being the house mother and all these girls go to her with their problems, I knew that anything that I could tell her she's heard before or heard worse.” --Racheli

"I'd say, the Rav is always first, our posek (Rabbi of Jewish law) especially the one who helps us make decisions, who knows the family situation, who knows where we're coming from, who knows where we're going, who has helped us until here, who knows our emotional background, and what could be an issue for us. We for sure go there first, and he's always the most helpful. You definitely leave there knowing that you're much more settled and you know you're doing the right thing." --Rivka Gittle

″When it was really hard, as I said, besides going to this yoaytz hinohi (child specialist), this man that helped us guide us on how to deal with our child and help the child. He was getting a connection with the child. He eventually helped us find somebody who was also like a big brother type, which I had been searching on my own for a long time for that child and hadn't found, whether it was through organizations or through individuals."--Beth

"Why I chose my friend first? Why decide her? Because I have a friend I could confide in, and...why not? She was a nice, educated, sensible lady that I trust. We have a good relationship, so we often speak out all sorts of other things. "--Michal

Unhelpful

“Short of that, to find somebody who was...like this therapist, I think, was good and sensitive, but it was dragging and dragging and dragging. It never really got to what to do. It was all background and theory and it wasn't even like, "Try this exercise." There was nothing to do with it. Or if any insight would come up, it was like, "OK, out of time. That's it. Good luck." It felt more pressing than that.” --Chani

"Basically, it was very frustrating. Because it was very good advice she [a child specialist] gave us, she taught us a very good lesson for life, just to ignore certain things , like, her whole thing. But I just didn't feel it was working for Racheli [our daughter]. She was going nowhere with it."-- Rebecca

"I used to turn to people. They'd be on the phone with me, and we'd go back and forth until they got me to just be crying and crying and crying. Or I'd go to a psychologist

or any kind of therapist, and I'd be crying and crying. They'd tell me the hours to come back again. Or if it was a friend, the friend would let me stay on the phone for a while. I never found that was useful. People tell, 'Oh, just cry it out.' Crying doesn't help me. I know that doesn't help. I have to do very positive things." --Susan

"Sometimes I do have friends who overwhelm me with trying to calm me down. They overwhelm me in the calming down process with too many details or too many facts or too many advice giving, too much...Yeah, I have such friends, too."--Gitty

Evaluation

Codes for the participants assessment of the help-seeking process (i.e. would he/she use a similar process, the same resources again). This code is different than "Perception of Helper" which looks at individual helpers and an assessment of their helpfulness; "Evaluation" is the participants' after-the-fact reflection on the process, what they would and would not repeat and meaning they made from the experience.

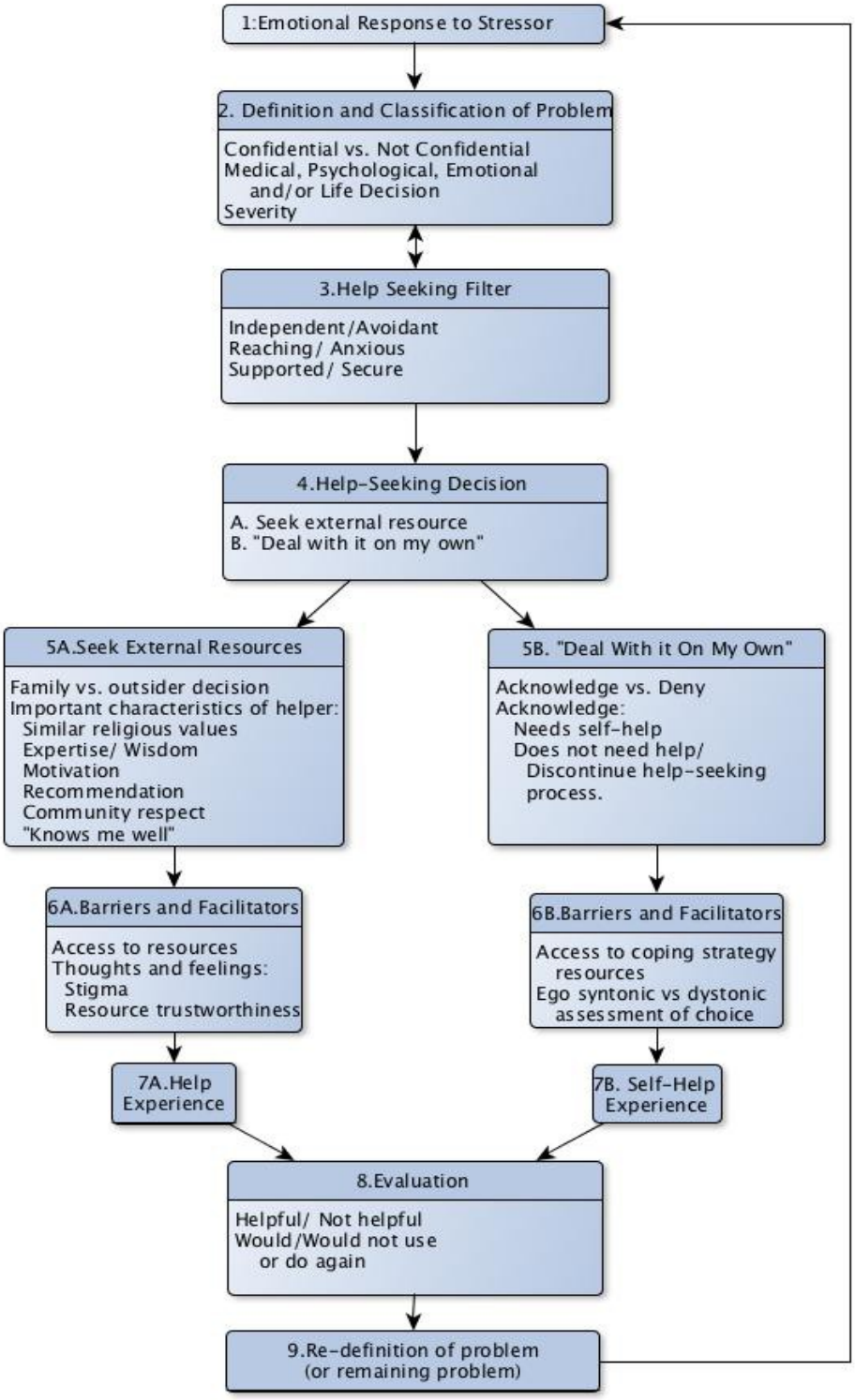
"The next day, when I was able to do it [deal with some difficulties with Israeli health insurance], and I had coping mechanisms, it felt good at the end because I overcame an obstacle, something that the day before was a landmine emotionally." --Eden

"This situation ended up being a lot easier because I've already been through the whole process. I already know who I trust and they're usually on point. I'm usually getting good advice. And if I follow good advice it's usually a good thing." --Aaron

"But the truth is you have to have the right outlook to appreciate the help. You know you're spending money on something that's worthwhile, especially if you click with the person and you hit it off, and she understands you. I remember feeling very good, coming out and feeling it was worth the investment. But it was a big hurdle, I thought, while it was time for me to go to her." --Michal

"It's very interesting, both of them, both of Rabbi Aaron Leib and.., they didn't really make a decision outright which is a very shrewd thing. Actually, now I'm thinking about it, I remember when my son was born and we both had stress of what to name him because my wife had a grandfather that was nifter (passed away) a long time ago--she has a brother named after him already--and my father was expecting a certain name and it was a big politics and also there, what I did is I went to Rav Nosson Tzvi Finkel (very well respected Rabbi). There, there was so much else going because I just really had no idea. Whatever you tell me to do, I'm just doing. Really, he didn't make a decision. He talked it out with you and based off of that, he was sort of like, 'OK, you got to your answer and it's OK. The decision that you are making in our value system is a good decision.' They all sort of did that. "--Yosef

Appendix E: Help-Seeking Flow Chart: Summary of Theory That Emerged from Coding



Appendix F. Participant Check Document

Dear Participant,

Thank you for your participation in this study! I am in the process of writing up my results and would deeply appreciate your input. The following is the theory that came out of in-depth analysis of 26 interviews with 13 women and 13 men who consider themselves part of the Orthodox or Ultra-Orthodox community in Jerusalem. My hope is that this information will be useful for therapists and community organizations that provide services to our community.

Included in this document is:
1.Three categories of "help-seeking filters" people described that influence how they get help in times of emotional stress.
2. A flow chart of the process people used when looking for help and a description of the flow chart.
3. Interesting findings

I have tried to keep this document brief in consideration of your time. If you would like more information, I am happy to discuss the results in more depth. My phone number is 052-481-4086; I am contactable by email at helpseekingresearch@gmail.com

The last page of this document asks for your feedback. If you have internet access, you can email the responses (helpseekingresearch@gmail.com). If you are receiving this document by mail, you can return the last page in the stamped envelope included. Please return this page by March 1st.

Thank you again!

I look forward to hearing from you.

Sincerely,

Ilyssa Bass

Three Types of Help-Seeking Filters:

Although I present these as three separate categories, I hypothesize that the groups fall on a spectrum: Avoidant-->Independent-->Supported/Secure-->Reaching-->Anxious. As you read, please consider whether or not one of these categories accurately describes your "help-seeking filter," the way you generally think about getting help.

Independent/Avoidant. This group of participants described a more internal, self-reliant help-seeking pattern. They emphasized the capacity to deal with one's own problems. On one side of the spectrum, participants saw this as a characteristic they were comfortable with and that did not necessarily stop them from seeking outside help if they felt they could not manage the situation on their own. On the other side of the spectrum, participants described avoidance as a coping mechanism that left them feeling unsupported and alone in times of stress. Participants tended to describe this independence or avoidance as more characterological (part of their personality) than situational or life-phase oriented.

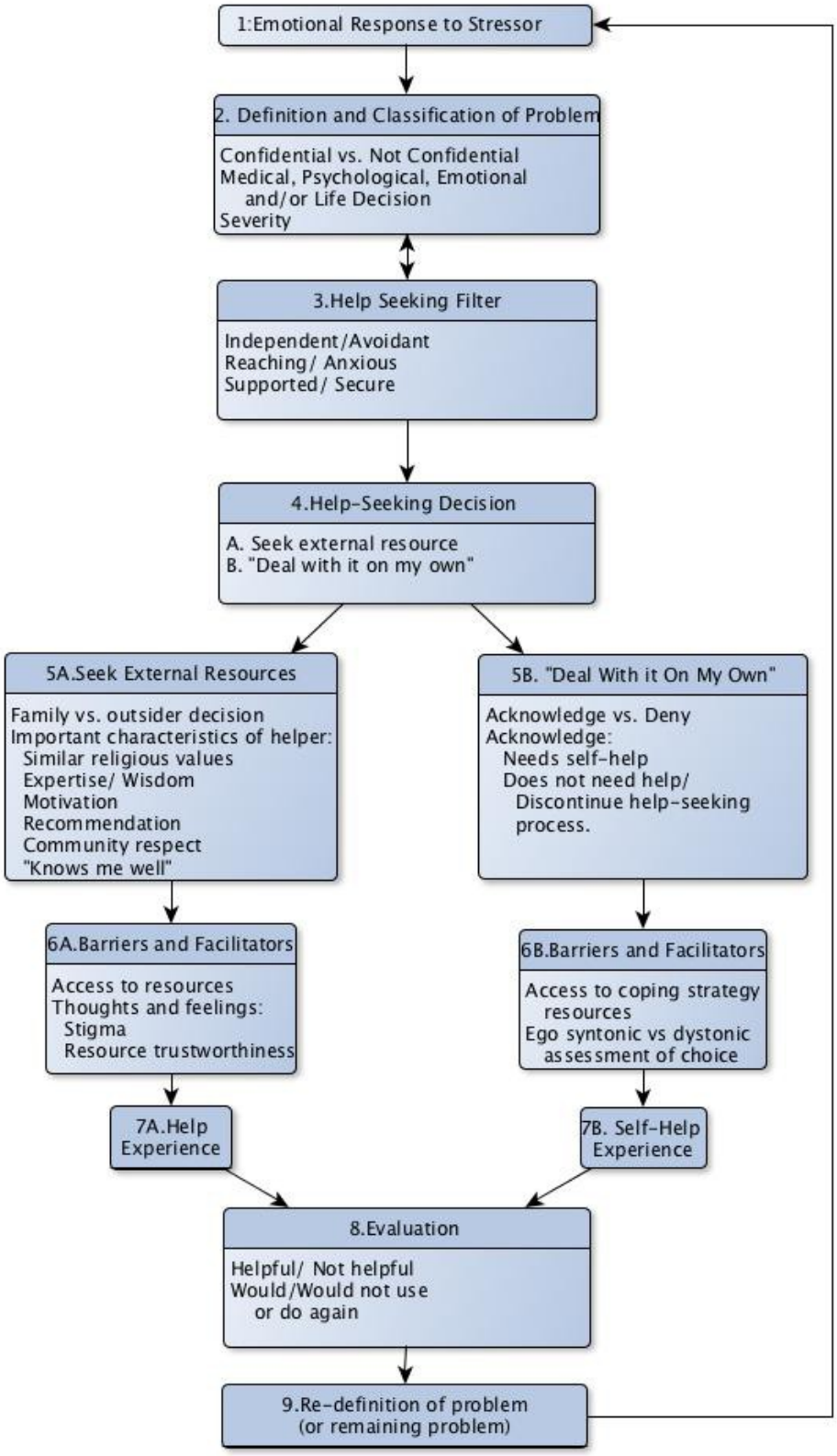
Reaching/Anxious. This group of participants described their help-seeking process as one with a lot of trial and error, reaching out, having an experience, and reaching out again. Some participants described themselves as “anxious,” describing an emotional uneasiness unless they felt that they had gathered a significant amount of information from multiple sources. Others described this help-seeking pattern as a developmental phase, before a supported or secure support system had been set up in their new community or life phase.

Supported/ Secure. These participants tended to describe the “ideal” help-seeking pattern they might advise for someone else as their own pattern. They described satisfaction with their support network, little resistance to seeking-help and a feeling of relative calm, or at least significantly decreased stress, after reaching out to their support network. This group did not necessarily describe more “successful” outcomes in terms of situational outcome, but rather reported a more “stream-lined” help-seeking process resulting in a general feeling of support throughout the time of stress they described. These participants tended to describe a comfortable and flexible pattern of behavior, a satisfaction with their support system and an overall effectiveness of their pattern on decreasing stress.

Please provide feedback on the last page about whether or not you feel that one of these categories describes you.

Thank you!

Help-Seeking Process Described by Participants



Description of Overall Help-Seeking Process:

The following is a brief summary of the flowchart. Some participants described the stages explained as a conscious process, others outlined the process through their description of their stressful situation. As you read, please consider whether or not this process includes the process you feel you use when looking for help:

Stage 1: First, there is an emotional experience of the stress.
Stage 2: Then, a classification of the problem (is this something I want to keep confidential? Is this something I'm comfortable sharing? Is this problem medical, psychological, spiritual, a life-decision, etc.? How severe is it?).
Stage 3: Then, most participants described what I call a "help-seeking filter," the way they generally approached getting help; this seemed to be based on personality characteristics, past experience, learned messages and perceptions of the acceptability of help in the community for the type of problem they were having. I found three major categories of help-seeking filters, which I described earlier.
Stage 4: After (1) the emotional experience, (2) classification of the problem and (3) application of a help-seeking filter, participants described a decision between looking for external help or dealing with the situation independently.
Stage 5a: Those who chose external resources often noted a decision about keeping the problem in the family or seeking other resources. In general participants noted the following as important characteristics of a helper: similar religious values, expertise, wisdom, motivation (what is the helper's motivation for helping), recommendation for a trusted person, community respect and knowing the individual well.
Stage 5b: For those who chose not to seek external help, there was a choice between acknowledging the problem or minimizing or denying it. For those who acknowledged their stress, there was a choice about what strategies and coping mechanisms to use and whether or not it was a problem that needed their attention at the time (some participants acknowledged the stress and chose not to focus their resources on it).
Stage 6a: Once the decision about whether or not to seek help was made, participants describes barriers and facilitators to finding the help they needed. For those who sought outside resources, access to the resources (primarily availability of the person or organization they sought out, transportation and cost) and thoughts and feelings about what it means to seek help (perceptions of stigma) often stood in the way of getting help. Many participants described a knowledgeable and well-connected individual who facilitated finding appropriate resources.
Stage 6b: For those who described a situation where they chose to manage the situation and stress on their own, access to their coping strategies (exhaustion was a frequently mentioned barrier) and, again, their own thoughts and feelings about their choice not to seek external help facilitated or impeded their ability to manage the stress on their own.
Stages 7a&b: Finally, the help (self-help or external help) experience occurred.
Stage 8: Next, the individual evaluated the experience ("Was it helpful or unhelpful? Was it something I would do again?")
Stage 9: Then, the person re-assessed the problem ("Is there some new aspect I need to address now?). If there was still an aspect of the problem that came with an experience of

distress, the process continued, starting at step one.

Please provide feedback on the last page about whether or not you feel that this process describes the process you use when you are experiencing emotional stress.

Thank You!

Interesting Findings

- There were very big gender differences. Women tended to contact family or a close friend first in times of distress and a mentor or Rebbetzin if the subject matter felt confidential (i.e. a Shalom Beis issue). Men involved in the Yeshiva system learning or teaching tended to go first to a mentor or Rav; other working men tended to express a self-reliance, trying to work out the stress on their own before going to family or Rebeum.

- Some participants categorized their spouse as part of a process of "dealing with it on my own," while others considered a spouse someone to reach out to.

- There were VERY different perceptions about stigma and what it means to go for help. These different perceptions did not seem to be influenced by characteristics like FFB vs. bale teshuva, Yeshivish vs. Hassidish, type of problem (medical, psychological, life-decision, etc), socioeconomic status or male vs. female. I hypothesize that it had much more to do with learned messages and what became a "help-seeking filter." Some participants felt that it is expected and normal to ask for help in times of stress, while others felt it was a sign that something is wrong with the family and might effect community status and shidduchim.

- There were also very different perceptions about the availability of psychological resources in the community. Some felt like there are many organizations and opportunities for help, others expressed a complete lack of resources. There was consensus that it is much more difficult to find out about therapists than it is about medical professionals.

- Transportation came up very frequently as a barrier to seeking outside support. Cost also came up frequently, but transportation more so.

- Almost all participants noted the importance of seeking emotional help (from a mentor, friend or professional) from someone with similar hashgafa. This is in contrast to some research in the US that indicates that many Orthodox Jews prefer to go to a secular therapist, mostly because they want to keep the problem confidential/ outside of the community. Several participants noted that they did not feel they could ever seek psychological help from a secular therapist.

- For men who went to therapy, a Rav was the primary referral source; for women, friends and sometimes family members were the primary referral source.

- Younger women (under 35) expressed a strong message either from their schooling or the community that a woman should have a formal mentor. Women in their 20's spoke about a strong message in school to have one teacher you are close with as a mentor. Older women rarely mentioned this idea.

Name:_____

If you remember your pseudonym, you can put it.
You can also put your real initials or leave this blank.
You may be quoted in the written dissertation, but only under your pseudonym.

Questions:

The Three Types of Help-Seeking Filters:

Do you feel that your experience fits in to one of these categories? __Yes

__No

If so, to what extent do you feel your experience fits into one of these

categories?

If not, please explain.

What would you call the category that describes your experience?

Overall Help-Seeking Process:

Do you feel that this help-seeking process accurately describes the process you use to seek help? __Yes __No

To what extent do you feel your experience fits the process described (please circle one)?
(0) Not at all, (1) A little, (2) Somewhat, (3) Moderately, (4) Fairly Accurately, (5) Accurately, (6) Very Accurately

If you feel that the described process does not fit your experience, please explain what does not fit for you:

How would you change the description/flowchart to more accurately describe your process?

Additional Questions, Comments or Concerns?